PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

00617

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:
County Montgomery Co.
City or town Burtonsville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 45 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md. County Montgomery
City or town Burtonsville (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME Sarah Catherine Athey
3. (b) Social Security Number —

4. Sex F
5. Color or race W
6.(a) Single, married, widowed, or divorced Widowed
6.(b) Name of husband or wife George W. Athey
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) 1862
8. AGE: Years 82 Months Days If less than one day ...hrs. ...min.
9. Birthplace Highland Howard Co. Md. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Home
FATHER 12. Name Brompton Thompson
13. Birthplace Md.
MOTHER 14. Maiden name Mary
15. Birthplace Germany
16. Informant Francis S. Conway
Address Burtonsville, Md.
17. Burial (Burial, cremation, or removal (Which?)) Date thereof Jan 29 1945 (month) (day) (year)
Cemetery or crematory St. Mary's Cemetery
Location Laurel Md.
18. Funeral director Wm. Wright Donaldson
Address Laurel, Md.
19 Jan 29 1945 (Date rec'd by registrar) M Brashears Laurel, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 27 1945 at 1:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-8 1944, to Jan 27 1945 and that I last saw her alive on Jan 25 1945
Immediate cause of death Cerebral Haemorrhage — DURATION 3
Due to
Due to
Other conditions Arterio Sclerosis Hypertension (Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE N. B. [illegible] (Steward) M. D. or other
Address Laurel Date signed 1/27/45

Rec'd by Gertrude Lawler Jan. 30, 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

00618

CERTIFICATE OF DEATH

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 52 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 52 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Wisc. County:

City or town: Green Bay
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: BASSETT, Frances Whiting

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	W-US	married

6.(b) Name of husband or wife: Lt. Robert C. Bassett

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 24 April 1916

8. AGE: Years	Months	Days	If less than one day
28	9	7	hrs. min.

9. Birthplace: Wis.
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business: hous

FATHER
12. Name: Frank Rockway
13. Birthplace: Wisc.

MOTHER
14. Maiden name: Sarah Graves
15. Birthplace: Vt.

16. Informant: husband: Lt. Robert C. Bassett
Address: 888 N. Kentucky St., Arlington, Va.

17. removal (Burial, cremation, or removal. Which?) Date thereof: Feb. 1, 45 (month) (day) (year)

Cemetery or crematory:

Location: Neenah, Wis.

18. Funeral director: W. W. Chambers RMG
Address: 1400 Chapin St., N.W., Wash., D. C.

19. Feb. 1 (Date rec'd by registrar) 19 45 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 31 SF 19 45 at 6:48 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 11 SF 19 44, to Jan 31 19 45
and that I last saw h SF alive on Jan. 31 SF 19 45

Immediate cause of death	DURATION
Pulmonary Edema & Severe Anemia, Secondary	24 Hours
Due to:	
Due to: Chronic Nephritis with Anemia	2 Months
Other conditions: Hyper tension	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.

Autopsy results: Not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Gordon R. Lamb M. D. or other

Address: Nat. Nav. Med. Center Date signed: Feb 1 '45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

00619

CERTIFICATE OF DEATH

Reg. Dist. No. 716

1. PLACE OF DEATH

County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, institution, or street address where death occurred: Suburban Hospital

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: County: Washington DC

City or town: (If outside city or town limits, write RURAL and give nearest town)

Street No. 2480 - 16 st N W

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME

(Mrs.) Anne Bastable

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	Married

8.(b) Name of husband or wife: Mr. Edward Bastable

8.(c) If alive, give age: 79 years

7. Birth date of deceased (mo., day, yr.): July 5 1876

8. AGE: Years	Months	Days	If less than one day
69	6		hrs. min.

9. Birthplace: Washington DC (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: Mr. Mc Dyde

13. Birthplace: Ireland

MOTHER — 14. Maiden name: Sheridan

15. Birthplace: Ireland

16. Informant: Husband

Address: 2480 - 16 st NW

17. (Burial, cremation, or removal. Which?) Removal Date thereof (month) (day) (year) 1-11-44

Cemetery or crematory:

Location: Rock DC

18. Funeral director: The S.H. Hines Co.

Address: 2901 - 14 st N.W. Washington DC

19. (Date rec'd by registrar) 1-11-44 19.... W. E. Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1-11-45 19.... at 4:12 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 7 1945, to Jan 11 1945 and that I last saw h.. alive on Jan 10 1945

Immediate cause of death	DURATION
Coronary thrombosis with infarction	
Due to Coronary sclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Paul D Cantor MD M. D. or other

Address: 7425 Wisconsin Ave Date signed: 1/11/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(1)

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

00620

CERTIFICATE OF DEATH

Reg. Diat. No. 218

1. PLACE OF DEATH:

County Montgomery

City or town Germantown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? —

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Germantown

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME Mary J. Boland

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband ~~or wife~~ Harry M. Boland

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 28, 1874

8. AGE: Years	Months	Days	If less than one day
70	2	7	..... hrs. ..... min.

9. Birthplace Md. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

FATHER 12. Name Joshua Dorsey

FATHER 13. Birthplace Md.

MOTHER 14. Maiden name Valeria Pumphrey

MOTHER 15. Birthplace Md.

16. Informant Miss Marie D. Boland

Address Germantown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 8, 1945 (month) (day) (year)

Cemetery ~~or crematory~~ Neelsville Presbyterian Church Cemetery

Location Neelsville, Md.

18. Funeral director Warner E. Pumphrey

Address Silver Spring, Md.

19. Jan. 7 1945 Elmer L. Cook Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 5 1945, at 8:10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1944, to Jan 5 1945, and that I last saw h... alive on Jan 5 1945.

	DURATION
Immediate cause of death: Pneumonia	2 days
Due to: Chronic cardio-renal disease	6 mo.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE F. J. Broadhurst M.D. M. D. or other

Address Gaithersburg Date signed 1-6-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-21)

CERTIFICATE OF DEATH

00621

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery Co.

City or town: Bethesda - Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Suburban Hospital

How long in hospital or institution? 3 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Montgomery Co.

City or town: Kensington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 9358 Georgetown Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Ida Brice

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Black.	married.

6.(b) Name of husband or wife: Adolphus Brice.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 13 - 1888

8. AGE: Years	Months	Days	If less than one day
56 —	3	12	..... hrs. ..... min.

9. Birthplace: Montgomery Co. - Md. (Town, county, and state)

10. Usual occupation: H. W.

11. Industry or business

FATHER

12. Name: Joseph Newman

13. Birthplace ?

MOTHER

14. Maiden name: Elizabeth Rhodes.

15. Birthplace: Montgomery Co. - Md.

16. Informant

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 30, 1945 (month) (day) (year)

Cemetery or crematory: Rhodes Cemetery

Location: Bethesda, Md.

18. Funeral director: R. L. Snowden

Address: 246 N. Wash. St Rockville Md.

19. 1/30 1945 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 27 1945, at 4:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-24 1945, to 1-27 1945 and that I last saw h... alive on 1-27 1945

Immediate cause of death	DURATION
Cardio - respiratory failure	3 days
Due to: Hypertensive heart disease	15 years
Due to: ? increased arterial tension	? years
Other conditions: Left hemiplegia (Include pregnancy within 3 months of death)	

Major findings of operations

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Joseph C Haugan M. D. or other

Address: Rockville Md. Date signed 1/28/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

00622

Reg. Dist. No. 23

1. PLACE OF DEATH:
County: MONTGOMERY
City or town: TAKOMA PARK
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years
Hospital, Institution, or street address where death occurred:
24½ CARROLL AVE
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Montgomery
City or town: TAKOMA PARK
(If outside city or town limits, write RURAL and give nearest town)
Street No. 24½ CARROLL AVE
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Flora E. Briggs

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): MAR 17, 1886

8. AGE: Years: 58 | Months: 9 | Days: 16 | If less than one day: ..... hrs. ..... min.

9. Birthplace: LASALLE, NEW YORK.
(Town, county, and state)

10. Usual occupation: STENOGRAPHER.

11. Industry or business

FATHER
12. Name: OSCAR J. BRIGGS.
13. Birthplace: BAKER SPRINGS, N.Y.

MOTHER
14. Maiden name: FLORENCE ADELAIDE ALDRICH.
15. Birthplace: WARTLAND CORNERS, N.Y.

16. Informant: OWEN L. BRIGGS
Address: MCLAIN, VA.

17. Burial (Burial, cremation, or removal. Which?) Date thereof JAN 6, 1945 (month) (day) (year)
Cemetery or crematory: George Mark Memorial Cemetery
Location: Riggs Rd. & Hyattsville, Md. R.F.D.

18. Funeral director: Arthur Waters.
Address: 25 Carroll St. N.W., Takoma Park, D.C.

19. Jan 3 1945 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION 1945

20. DATE OF DEATH: Jan 2 1945, at 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 31 1944 to Jan 2 1945
and that I last saw h alive on Jan 2 1945

Immediate cause of death	DURATION
Cerebral embolism	Unknown
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Frank J. Brockhurst M.D. M. D. or other
Address: Post Grad. Exam. Date signed: Jan 2 - 45

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

CERTIFICATE OF DEATH

2363

00623

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Suburban Hospital
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Kensington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 9515 W. Stanhope Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: William Albert Brooks

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	widower

6.(b) Name of husband or wife: Sallie
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 15, 1856.

8. AGE:

Years	Months	Days	If less than one day
88	3	6	hrs. min.

9. Birthplace: Charlotte Co. Virginia (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business:
12. FATHER — Name: Thomas Brooks
13. FATHER — Birthplace: Charlotte Co., Va.
14. MOTHER — Maiden name: Sallie Booth
15. MOTHER — Birthplace: Charlotte Co., Va.
16. Informant: Dr. Edward B. Brooks
Address: same
17. Shipment (Burial, cremation, or removal. Which?) Date thereof 1/22/45 (month) (day) (year)
Cemetery or crematory: Oakwood Cem.
Location: Chase City, Va.
18. Funeral director: Wm Reuben Humphrey
Address: 7557 Wis. Ave. Bethesda, Md.
19. Jan 22 1945 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 21 19 45 at 4:02 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 16 19 45 to Jan 21 19 45 and that I last saw h.. alive on Jan 21 19 45

Immediate cause of death	DURATION
Due to	
Due to	
Other conditions: Senility.	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Edward B. Brooks M. D. or other
Address: 1736 Eye St. N.W. Washington 6 D.C. Date signed: 1/21/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (196)

CERTIFICATE OF DEATH

00624

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3months & 26 days
Hospital, institution, or street address where death occurred:
U.S.Naval Hospital, Bethesda, Md.
How long in hospital or institution? 3 months & 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Va. County:
City or town: Charlottesville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1929 Lewis Mountain Road
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: BROOME, Roger Greville Brook, Major USMCR

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Jane Broome
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 26, 1915

8. AGE:

Years	Months	Days	If less than one day
29	5	22	hrs. min.

8. Birthplace: Washington (Town, county, and state)
10. Usual occupation: Marine Corps
11. Industry or business:
FATHER 12. Name: Nathaniel Broome
13. Birthplace: Va.
MOTHER 14. Maiden name: Elsie Anderson
15. Birthplace: Va.
16. Informant: Wife: Mrs. Jane Broome
Address: 1929 Lewis Mountain Rd., Charlottesville, Va.
17. removal (Burial, cremation, or removal. Which?) Date thereof: 1-18-45 (month) (day) (year)
Cemetery or crematory:
Location: Louisa County, W.Va.
18. Funeral director: W. W. Chambers
Address: 1400 Chapin St., N. W., Wash., D. C.
19. January 18 1945 (Date rec'd by registrar) marycharlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 18 January 1945, at 0700 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 22 Sept. 1944, to 17 January 1945
and that I last saw him alive on 17 January 1945

	DURATION
Immediate cause of death: Traumatic Amputation Left Lower extremity	8 Mons
Due to: Gun Shot Wounds enemy Action	
Due to:	
Other conditions: Malaria	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: Confirm Clinical Findings
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: James McAteer M. D. or other
Address: US N.H., Bethesda, Md. Date signed: 1-18-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (195-2)

00625

CERTIFICATE OF DEATH

Reg. Dist. No. 2-8

1. PLACE OF DEATH:
County Monty
City or town Buckeystown - (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Monty
City or town Buckeystown - Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Herman Russel - Brown

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife Ethel M. Browne
6.(c) If alive, give age 40 years
7. Birth date of deceased (mo., day, yr.) Oct. 14, 1901

8. AGE:

Years	Months	Days	If less than one day
43	2	26	hrs. min.

9. Birthplace Maryland -
(Town, county, and state)
10. Usual occupation Fireman on R.R. Railroad
11. Industry or business
FATHER 12. Name Herman F. Brown
13. Birthplace md
MOTHER 14. Maiden name Ella Cooper
15. Birthplace md
16. Informant Raymond Brown -
Address 312 Crapton - Ave Baltimore
17. Buried (Burial, cremation, or removal. Which?) Date thereof 1-16-45 (month) (day) (year)
Cemetery or crematory Glenhaven - 1/10/45 -
Location Glenhaven md -
18. Funeral director John F. Denney Inc
Address 716 - Eight - H Baltimore md -
19. Jan 10 1945 Alveda G. Cooke
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 10 19 45 - at 12 45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. Med. Exam 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Fracture of base of skull	Killed instantly
Due to explosion of R.R. engine	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 1-10-45 -
Where did injury occur? Buckeystown (City or town) Monty (County) Md (State)
Injured at home, farm, industry, public place (where?) B & O. R.R.
Means of injury explosion of engine Injured at work? Yes
23. SIGNATURE Frank J. Bouchart
Dep. Med. Exam M. D. or other
Address Gaithersburg md Date signed 1-10-45

M

1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

00626

CERTIFICATE OF DEATH

Reg. Diat. No. 217

1. PLACE OF DEATH:

County Montgomery

City or town Colesville.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Colesville.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Martha S Brunett

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed.

6.(b) Name of husband or wife Julian M. Brunett

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 16, 1872

8. AGE: Years	Months	Days	If less than one day
72	8	15	..... hrs. ..... min.

9. Birthplace Burnt Mills, Maryland.
(Town, county, and state)

10. Usual occupation Retired Housewife.

11. Industry or business

FATHER 12. Name Wm. E. Shaw

13. Birthplace Maryland.

MOTHER 14. Maiden name Annie M. Fawcett

15. Birthplace England.

16. Informant Raymond S. Brunett (Son)

Address 1235 Randolph St, N.W. Wash. D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: February 2, 1945 (mouth) (day) (year)

Cemetery or crematory St John's Cemetery

Location Forest Glen Md.

18. Funeral director Warner E. Pumphrey

Address Silver Spring, Md.

19. Jan 31 1945 (Date rec'd by registrar) Gertrude B. Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 31 1945, at 7 45 a. m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/15/44 to 1/31/45 and that I last saw h.. alive on 1/29/45

Immediate cause of death	DURATION
(a) Tuberculous Mycroditis	6 mos
Due to (b) Cardiac Dilation	2
Due to	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE [signature] M. D. or other

Address Sandy Spring, Md. Date signed 1/31/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94)

00627

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:
County Montgomery
City or town Sandy Springs
(If outside city or town limits, write RURAL, and give nearest town)
How long in above place of death? all life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Sandy Springs
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Tyson A. Budd

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Colored	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 16, 1882

8. AGE: Years	Months	Days	If less than one day
62	8	8	..... hrs. ..... min.

9. Birthplace Sandy Spring, Md. (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business
12. FATHER — Name Samuel W. Budd
13. FATHER — Birthplace Sandy Spring, Md
14. MOTHER — Maiden name Harriett Ann Squirrel
15. MOTHER — Birthplace Sandy Spring, Md
16. Informant Mrs Effie J Bolton
Address Selby Springs, Md (Sister)
17. Buried (Burial, cremation, or removal. Which?) Date thereof Jan. 28 1945 (month) (day) (year)
Cemetery or crematory Sandy Springs
Location Sandy Springs, Md
18. Funeral director Robert L Snowden
Address 246 N. Wash St Rockville
19. Jan. 28 1945 (Date rec'd by registrar) Gertrude B. Compton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 24 1945, at 11:45 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 31 Med Exam 1944 to ..... 19..... and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary occlusion	dur. suddenly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Ernest J Bouchart M.D. Dep. Med Examiner M. D. or other
Address Gaithersburg Md Date signed 1-24-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

00628

CERTIFICATE OF DEATH

Reg. Diat. No. 2/3-

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County Montgomery

City or town Silver Spring Orchard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Spring Orchard

(If outside city or town limits, write RURAL and give nearest town)

Street No. Gaithersburg Md R.F.D.

(If rural, give LOCATION)

2.(a) If veteran, name war no

3.(a) FULL NAME Hannah Burris

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife Isaac Burris

6.(c) If alive, give age dead years

7. Birth date of deceased (mo., day, yr.) unknown

8. AGE: Years	Months	Days	If less than one day
about 65			hrs. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation House work

11. Industry or business

FATHER

12. Name Kit Kramer

13. Birthplace Maryland

MOTHER

14. Maiden name unknown Kisner

15. Birthplace Prince George Co Md

16. Informant Hannah Burris

Address Gaithersburg R#3

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/29/45 (month) (day) (year)

Cemetery or crematory Lay Hill Meth Episcopal Ch

Location Lay Hill Md

18. Funeral director Wm Reuben Humphreys

Address Rockville, Maryland

19. 1/28 (Date rec'd by registrar) 1945 Josephine D. Hatton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 26 1945 at 1 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 25 1945 to Jan 26 1945 and that I last saw h. alive on Jan 25 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 day
Due to Arterio Sclerosis	unknown
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Vernon H. Dyson M. D. or other

Address Laytonsville Date signed Jan 27/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (78-B)

CERTIFICATE OF DEATH

00629

Reg. Dist. No. 2/2

1. PLACE OF DEATH:

County: Montgomery

City or town: Rockville (Rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 1/2 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Montgo

City or town: Burnesville, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Alamp Carter

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Catherine Carter

6.(c) If alive, give age: 33 years

7. Birth date of deceased (mo., day, yr.): Sept 9 - 1918

8. AGE:

Years	Months	Days	If less than one day
26	4	9	..... hrs. ..... min.

9. Birthplace: Bland Grayfield Va.

(Town, county, and state)

10. Usual occupation: Farmer Laborer

11. Industry or business

FATHER

12. Name: James Carter

13. Birthplace: Virginia

MOTHER

14. Maiden name: Mary A Carter

15. Birthplace: Va.

16. Informant: James Carter

Address: Rockville, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/21/45 (month) (day) (year)

Cemetery or crematory: Monocacy

Location: Beallsville, Md.

18. Funeral director: William B Hilton

Address: Barnesville, Md.

19. Jan. 19, 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 18 1945, at 5:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 31 1944 to Jan 18 1945

and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
(a) Asphyxia	3 min.
(b) Coma	2 days
Due to: (a) Carbon monoxide poisoning (accidental)	
Due to: (b)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accidental Date of 1-18-45

Where did injury occur? Rockville (City or town) Montg (County) Md (State)

Injured at home, farm, industry, public place (where?) Ford dump truck

Means of injury Injured at work?

23. SIGNATURE: Frank J. Brockett M.D.

Dep. Med. Exam. M. D. or other

Address: Gaithersburg Md Date signed 1-18-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

00630

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:
County Montgomery
City or town Olney, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
The Montgomery County General Hospital Inc.
How long in hospital or institution? 1 day.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Olney
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mr. Frank Cashell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mrs. Eva Cashell
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 25, 1869

8. AGE: Years 75 | Months 1 | Days 3 | If less than one day hrs. min.

9. Birthplace Olney, Montgomery Co. Md.
(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER 12. Name George C. Cashell
13. Birthplace Olney, Maryland.

MOTHER 14. Maiden name Anne E. C. Bansley
15. Birthplace Olney, Maryland

16. Informant Hospital records.
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 30, 1945 (month) (day) (year)
Cemetery or crematory St. Johns Cemetery
Location Olney, Maryland

18. Funeral director Warner E. Pumphrey
Address Silver Spring, Md.

19. Jan 30 1945 (Date rec'd by registrar) Gertrude B. Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 28 1945, at 5:10 P.M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 1 1945, to January 29 1945 and that I last saw him alive on January 28 1945

	DURATION
Immediate cause of death	
Acute Cardiac dilitation	24 hrs.
Due to	
Chronic Myocarditis With	
Due to hypertension	4 yrs.
Other conditions	
(Include pregnancy within 3 months of death)	

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other
Address Sandy Spring, Md Date signed 1/29/45

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00631

Reg. Diat. No. 2-27

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington Sanitarium + Hospital

How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 403 - 4th St N-E.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Mrs. Mary Elizabeth Caton

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	White	widowed

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 18, 1869

8. AGE: Years	Months	Days	If less than one day
75	2	22	hrs. min.

9. Birthplace: Georgetown, Wash. D.C. (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business:

FATHER — 12. Name: —

13. Birthplace: —

MOTHER — 14. Maiden name: —

15. Birthplace: —

16. Informant: Friend Wash. Sem. + Hospital

Address: Takoma Park, Md.

17. (Burial, cremation, or removal. Which?) Date thereof: 1/10/45 (month) (day) (year)

Cemetery or crematory: Emmanuel

Location:

18. Funeral director: W. W. Lehmberg Co.

Address: 1400 Chapin St. N.W.

19. Jan 10 1945 (Date rec'd by registrar) J. Wilson Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 9 1945 at 11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 29 1944 to Jan 9 1945 and that I last saw h-- alive on Jan 9 1945

Immediate cause of death	DURATION
Bronchopneumonia	5 days
Due to Malnutrition Senility	6 mos
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE: Henry S. Brown M.D. M. D. or other

Address: Takoma Park. Md. Date signed: 1/10/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

00632

Reg. Dist. No. 2-16

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days -

Hospital, institution, or street address where death occurred: Suburban Hospital Bethesda Md

How long in hospital or institution? 1-18-45 - 1-23-45

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Bethesda Md County: Montgomery

City or town: Bethesda Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 304 Wilson Lane -

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

Mrs. Lydia Lee Thappell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	White. American	M W.

6.(b) Name of husband or wife: Ellsworth Thappell. (Head)

6.(c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): Nov. 8th, 1870

8. AGE: Years	Months	Days	If less than one day
74 years			....hrs. ....min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Housewife -

11. Industry or business: -

FATHER 12. Name: Robert Sherwood

13. Birthplace: Va

MOTHER 14. Maiden name: Mary Virginia Mills

15. Birthplace: Virginia

16. Informant: Mrs. Stella Tabler (Daughter) Kensington

Address: 4929 Crescent St. Crestfield Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/25/45 (month) (day) (year)

Cemetery or crematory: Eldbrooke Cemetery

Location: Wash. D.C.

18. Funeral director: Wm Reuben Dunphrey

Address: Bethesda, Md -

19. 1/23 1945 Wm E Jones Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 23rd 1945, at 1.52 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-17 1945, to 1-23 1945 and that I last saw h.... alive on 1-22-45 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to: Arteriosclerosis &	
hypertension	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Paul D Cantor M.D. M. D. or other

Address: 7425 Wisconsin Date signed 1/23/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-6)

00633

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:
County: Montgomery
City or town: Fairland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? From 10/30/44
Hospital, Institution, or street address where death occurred: Cedarcroft Sanitarium
How long in hospital or Institution? From 10/30/44

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington D.C. (If outside city or town limits, write RURAL and give nearest town)
Street No. 1144-46 St. S.E. (If rural, give LOCATION)
2.(a) If veteran, name war: none ✓

3. (a) FULL NAME: GEORGE FRANCIS CLIFFORD

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: Margaret T. Nieset deceased
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): January 4, 1870

8. AGE: Years	Months	Days	If less than one day
75	--	7	....hrs. ....min.

9. Birthplace: Ligonier, Pa. (Town, county, and state)
10. Usual occupation: policeman (retired)
11. Industry or business

FATHER
12. Name: Charles Clifford
13. Birthplace: Ligonier Pa.

MOTHER
14. Maiden name: Jennie A. Ramsey
15. Birthplace: Ligonier Pa.

16. Informant: Mrs. Edward Gallagher
Address: 1144-46 St.S.E. Washington D.C

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Jan. 8, 1945 (month) (day) (year)
Cemetery or crematory:
Location: Ligonier, Pa.
19. Funeral director: G. J. Costello Co.
Address: Ligonier Pa. Wood D.C.

19. Jan. 8 1945 (Date rec'd by registrar) Josephine M. Schaffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 8 1945 at 8 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 30 — 1944, to Jan 8 — 1945; and that I last saw him alive on Jan. 7 — 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	6 days
Due to:	
Due to: Cerebral Arteriosclerosis	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Richard B. Thibadeau M.D. M. D. or osteo.
Address: Box 271 Silver Spring Md. Date signed: 1-9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00634

Reg. Dist. No. 716

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Suburban Hospital

How long in hospital or institution? 1/13/45 — 9:15 P.M.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Montg. Co.

City or town Brookmont
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6108 Ridge Drive
(If rural give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Catherine Culverwell (Culverwell)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	white	Married.

8.(b) Name of husband or wife Richard S. Culverwell

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 20, 1873

8. AGE: Years	Months	Days	If less than one day
71			hrs. min.

9. Birthplace Washington D.C. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business —

FATHER
12. Name — Roth
13. Birthplace Germany.

MOTHER
14. Maiden name —
15. Birthplace Germany

16. Informant

Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof Jan. 21, 1945 (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director Thomas F. Murray

Address 2007 Mitchigan Ave N.E.

19. Jan 21 1945 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 21 1945, at 6.35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 13 1945, to Jan. 21 1945

and that I last saw h[illegible] alive on 19

Immediate cause of death	DURATION
Uremia	
Due to Generalized Carcinomatosis	
Due to possibly Cancer of liver or pancreas	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation None Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W B Wardlaw M.D. M. D. or other

Address Suburban Hosp. Date signed 1/21/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (160-C)

00635

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH

County: Montgomery

City or town: Bethesda Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 hr. 13 min.

Hospital, institution, or street address where death occurred: NSNH Bethesda Md.

How long in hospital or institution? 1 hr. 13 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: ..... County: .....

City or town: Washington D.C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2319 40th Place N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war: V

3.(a) FULL NAME Baby Boy Davis

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Single

6.(b) Name of husband or wife: .....

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 25, 1945

8. AGE:

Years	Months	Days	If less than one day
			1 hrs. 13 min.

9. Birthplace: Montgomery Co. Maryland. (Town, county, and state)

10. Usual occupation: .....

11. Industry or business: .....

FATHER

12. Name: Frank Halbert Davis

13. Birthplace: Littlemountain, S. Car.

MOTHER

14. Maiden name: Rosie Lee Davis

15. Birthplace: Chattanooga Tenn.

16. Informant: Frank H. Davis

Address: 2319 40th Place. Wash. D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 27, 1945 (month) (day) (year)

Cemetery or crematory: George Washington Memorial

Location: Maryland (Hyattsville)

18. Funeral director: W.H. Chambers

Address: 1400 Chapin Street, N.W. Washington, D.C.

19. Jan. 26 1945 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 25 1945, at 6:05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 25 1945, to Jan. 25 1945 and that I last saw him alive on Jan 25 1945

Immediate cause of death	DURATION
Prematurity	
Due to	
Premature separation of Placenta	14 days
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Hattie W. Roberts M.D. M. D. or other

Address: 2151 NH Bethesda Md. Date signed 1/26/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94-a)

CERTIFICATE OF DEATH

00636

Reg. Dist. No. 214

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Monty
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 608 Greenbrier Dr.
(If rural, give LOCATION)
2.(a) If veteran, name war: World war ✕ II

3. (a) FULL NAME: Major Robert Stanley Dayhoff

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6.(b) Name of husband or wife: Glendora Dayhoff
6.(c) If alive, give age: 34 years

7. Birth date of deceased (mo., day, yr.): May 9 1909

8. AGE: Years	Months	Days	If less than one day
35	8	9	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Government Clerk
11. Industry or business

FATHER
12. Name: John W. Dayhoff
13. Birthplace: md

MOTHER
14. Maiden name: Mary Jane Kelbaugh
15. Birthplace: W. Va

16. Informant: Edward L. Dayhoff
Address: Silver Spring md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 20-45 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington Co Va.

18. Funeral director: Warner E Pumphrey
Address: 8436 Ga Ave Silver Spring, md

19. Jan. 19 1945 (Date rec'd by registrar) Josephine M Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 18 19 45, at 1:31 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. Med. Exam Case 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Acute Myocarditis	3 hrs.
Due to: Coronary sclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank J. Bonecutt M.D. M. D. or other
Address: Dep. Med. Exam. Gaithersburg md. Date signed 1-18-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (163-H)

00637

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: 4832 Park Ave. N. W.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Same above
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Monty
City or town: Friendship Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4832 Park Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Alfred Robinson Dean

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife: Bessie Viola
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 11, 1903

8. AGE: Years	Months	Days	If less than one day
43			..... hrs. ..... min.

9. Birthplace: Washington, D. C.
(Town, county, and state)
10. Usual occupation: Painter
11. Industry or business
FATHER 12. Name: Harry C. Dean
13. Birthplace: Md.
MOTHER 14. Maiden name: Lillian M. Dean
15. Birthplace: Virginia
16. Informant: Mrs. Lillian M. Dean
Address: 4832 Park Ave.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/20/45 (month) (day) (year)
Cemetery or crematory: Mt Zion Cemetery
Location: Maryland
18. Funeral director: Wm Reuben Cumpston
Address: 7557 Wis. Ave. Bethesda, Md
19. 1/19 19 45 Wm E Jones Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 18 19 45, at 1:30 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. Med. Exam case to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Asphyxia	Imd
Due to Self-inflicted gun	Imd
shooting (suicide)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of 1-18-45
Where did injury occur? Friendship Hts. (City or town) Monty (County) Md. (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Frank J. Broschart M.D.
Dep. Med. Exam. M. D. or other
Address: Gaithersburg Md. Date signed 1-18-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

00638

Reg. Diat. No. 7103

1. PLACE OF DEATH:
County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7003 Sycamore St.
(If rural, give LOCATION)
2.(a) If veteran, name war: World war # 1

3.(a) FULL NAME John F. Deller

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	?

6.(b) Name of husband or wife

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) June 29 1887.

8. AGE: Years	Months	Days	If less than one day
57	6	7	____ hrs. ____ min.

9. Birthplace: Harrisburg Pa
(Town, county, and state)
10. Usual occupation: Traffic expert
11. Industry or business: Interstate Commerce Commission

FATHER
12. Name: unknown
13. Birthplace

MOTHER
14. Maiden name: unknown
15. Birthplace

16. Informant: Walter Armstrong
Address: 1613 Massachusetts Ave NE Washington DC

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 9 1945 (month) (day) (year)
Cemetery or crematory: Arlington Nat'l Cemetery
Location: Arlington Va

18. Funeral director: Deal Funeral Home
Address: 4812 Baltimore Blvd

19. Jan 5 1945 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 5 1945; at 6:40 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 31 1944 to Jan 5 1945
and that I last saw h alive on Jan 5 1945

Immediate cause of death	DURATION
Coronary occlusion	died suddenly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Frank J. Broschart M.D.
Dep. Med. Exam. M. D. or other
Address: Silver Spring Md Date signed 1-5-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

00639

Reg. Diat. No. 214

1. PLACE OF DEATH:
County ~~Everett~~ Montgomery
City or town Silver Spring (Hillandale)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 yrs
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Monty
City or town Silver Spring (Hillandale)
(If outside city or town limits, write RURAL and give nearest town)
Street No. 200 Overlook Dr.
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME Ernest H. Ehlis

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Sept 29 1889

8. AGE: Years 55 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Brooklyn N. Y.
(Town, county, and state)

10. Usual occupation bookkeeping

11. Industry or business

MOTHER FATHER
12. Name Ernest A. Ehlis
13. Birthplace Germany
MOTHER
14. Maiden name Theresa Mueller
15. Birthplace Germany

16. Informant wife
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof Jan 10 1945 (month) (day) (year)

Cemetery or crematory
Location Washington Mem'l

18. Funeral director The D. E. Davis Co.
Address 2901 — 14th St. N.W.

19. 1/10/45 (Date rec'd by registrar) 19 Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 10 1945, at 2:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 31 1944 to Jan 10 1945 and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Coronary occlusion	5 days
Due to Chronic alcoholism	40 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Frank J. Bonsteel M.D.
Dep. Med. Exam. M. D. or other
Address Gaithersburg Md. Date signed 1-10-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (178-A)

00649

CERTIFICATE OF DEATH

Reg. Dist. No. 216

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Montgomery

City or town: Chevy Chase Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

6419 Brookville Rd

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Monty

City or town: Chevy Chase

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5419 Aberfoyle St

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Dr. Wilber E. Evans

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife: Jeannette W.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 16, 1872

8. AGE: Years	Months	Days	If less than one day
71			hrs. ..... min.

9. Birthplace: West Virginia (Town, county, and state)

10. Usual occupation: Dentist

11. Industry or business

FATHER — 12. Name: George F. Evans

13. Birthplace: West Va.

MOTHER — 14. Maiden name: Mary Mathews

15. Birthplace: West Va.

16. Informant: Robert H. Evans

Address: 6419 Brookville Rd

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/29/45 (month) (day) (year)

Cemetery or crematory: Rockville Union Cem.

Location: Rockville Md.

18. Funeral director: Wm Reuben Pumphrey

Address: 7557 Wis. Ave. Bethesda

19. Jan 28 1945 (Date rec'd by registrar) Wm E Jobes M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 26 1945, at 5:00 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1944 to Date 1945

and that I last saw h alive on 1945

Immediate cause of death	DURATION
(a) Asphyxia due to illuminating gas poisoning	2 hours
Due to (b) accidental	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accidental Date of 1-26-45

Where did injury occur? Chevy Chase (City or town) Monty (County) Md (State)

Injured at home, farm, industry, public place (where?) office

Means of injury Injured at work?

23. SIGNATURE: Frank J. Brockett M.D. Co. Med Exam M. D. or other

Address: Gaithersburg Md. Date signed 1-26-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

00641

CERTIFICATE OF DEATH

Reg. Dist. No. 214

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Kensington

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3½ yrs.

Hospital, institution, or street address where death occurred: 15 West Baltimore St.

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Kensington

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 15 West Baltimore St.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Juliette Marguerite Farrell

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Edward Farrell

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Nov. 11, 1859

8. AGE: Years: 85 | Months: 2 | Days: 7 | If less than one day: ... hrs. ... min.

9. Birthplace: New York (Town, county, and state)

10. Usual occupation: none

11. Industry or business: —

FATHER

12. Name: Julien Fontaine

13. Birthplace: France

MOTHER

14. Maiden name: Julienne Violette

15. Birthplace: France

16. Informant: Mrs. E.A. Farrell

Address: 15 W. Baltimore St. Kensington

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 22 1945 (month) (day) (year)

Cemetery or ~~crematory~~: Greenwood

Location: Brooklyn-Kings Co. N.Y.

18. Funeral director: Wade & Dingbey

Address: 8430 Georgia Ave, Silver Spring, Md.

19. Jan. 19, 1945 (Date rec'd by registrar) Josephine M. Schaffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 18 1945, at 3:13 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 25 1942 to Jan. 18 1945 and that I last saw her alive on Jan. 18 1945

Immediate cause of death	DURATION
Cardio-vascular-renal disease	10-20 years.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Katharine A. Chapman M.D. M. D. or other

Address: 20 W. Baltimore St Kensington, Md. Date signed 1/18/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 163-M

CERTIFICATE OF DEATH

00642

Reg. Dist. No. 716

1. PLACE OF DEATH:
County Montg.
City or town Bethesda (outside)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Found dead
Hospital, Institution, or street address where death occurred:
—
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State DC, County
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1721 H Heart St N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war World War # 2 ✓

3.(a) FULL NAME Samuel Feldman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

6.(b) Name of husband or wife Betty
6.(c) If alive, give age ..... years

7. Birth date of deceased (mn., day, yr.) May 30, 1905

8. AGE: Years	Months	Days	If less than one day
39			..... hrs. ..... min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual occupation Printer
11. Industry or business

FATHER
12. Name Samuel Feldman
13. Birthplace Russia

MOTHER
14. Maiden name Annie Stamler
15. Birthplace Russia

16. Informant Harry Feldman
Address 343 - 13th St. S.E.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/10/45 (month) (day) (year)
Cemetery or crematory Arlington Nath. Cem.,
Location Arlington, Virginia

18. Funeral director B. Danzansky
Address 3501 - 14th St N.W.

19. 1/10/45 (Date rec'd by registrar) Wm E Doles Registrar

2012 - Lot 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 6 1945, at 9:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. Med. Exam. care 19 to 19
aed that I last saw h alive on 19

Immediate cause of death	DURATION
Asphyxia (suicide)	Found dead
Due to Carbon mon. oxide gas	in car,
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Suicide Date of 1-6-45
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Frank J. Bouchart M.D.
Dep. Med. Exam. M. D. or other
Address Rockville, Md. Date signed 1-9-45

(M) (1) (T) VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. ✓

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (M5-2)

CERTIFICATE OF DEATH

00643

Reg. Diat. No. 218

1. PLACE OF DEATH:
County: Monty
City or town: Bucklodge (Route)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Monty
City or town: Bucklodge - Route
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Lloyd P. Frederick

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Elsie M - Hines
Mary
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1898

8. AGE: Years	Months	Days	If less than one day
1898 46	7	23	hrs. min.

9. Birthplace: Mahaska Co Iowa
(Town, county, and state)
10. Usual occupation: Engineer
11. Industry or business: —

FATHER
12. Name: Hubert Frederick
13. Birthplace: Iowa

MOTHER
14. Maiden name: Ella Frazier
15. Birthplace: Iowa

16. Informant: Mrs - Elsie - Hines Frederick
Address: 4401 (6th NE - Washington DC

17. (Burial, cremation, or removal. Which?) Date thereof: 1-10-45
(month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington Va

18. Funeral director: S H Hines Co
Address: 2901 - 14th N.W. Washington D.C.

19. Jan 10 19 45 Alma L Cooke
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 10 19 45 at 12 45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Dep. Med. Exam 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Comminuted fracture of skull	Killed instantly
Due to explosion of R.R. engine	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Accident Date of 1-10-45
Where did injury occur? Bucklodge (City or town) Monty (County) Md (State)
Injured at home, farm, industry, public place (where?) B & O. RR
Means of injury explosion of engine Injured at work? yes

23. SIGNATURE: Frank J. Brockett M.D.
Dep. Med. Exam.
M.D. or other
Address: Frank J. Brockett MD Date signed 1-10-45
Baltimore

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


RECEIVED
BUREAU U.S.
JAN 22 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-L)

00644

CERTIFICATE OF DEATH

Reg. Dist. No. 223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING VS A15

1. PLACE OF DEATH:
County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? One month & 12 days
Hospital, institution, or street address where death occurred:
Hillside Nursing Home 21 Sherman Ave.
How long in hospital or institution? One month and 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Howard
City or town: Rural - Woodbine
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Eleanor Warfield Gaither

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 18, 1876

8. AGE: Years: 68 | Months: 6 | Days: 4 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Woodbine, Howard Co., Md.
(Town, county, and state)

10. Usual occupation: House Keeper

11. Industry or business: Farm home

FATHER
12. Name: William Henry Gaither
13. Birthplace: Howard County, Md.

MOTHER
14. Maiden name: Susan Warfield
15. Birthplace: Laurel, Maryland

16. Informant: Mrs. F. O. Gaither
Address: Lanham, Maryland.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 1-23-45 (month) (day) (year)
Cemetery or crematory: Westminster Md
Location: Md

18. Funeral director: Huntsman Funeral Home
Address: 5732 Baltimore

19. JAN 23 1945 (Date rec'd by registrar) J. William Doll Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 22, 1945 at 11:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 11th, 1944 to Jan. 21, 1945 and that I last saw her alive on January 21, 1945

Immediate cause of death	DURATION
Cerebral Thrombosis	2 days
Due to: Arteriosclerosis, Cerebral and	?
Due to: Senile dementia	6 mo.
Other conditions: Hypertension, arterio-sclerotic	?

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Wallace N. Mook M.D.
M. D. or other
Address: 805 Carroll Avenue, Takoma Park 12, Md. Date signed 1/23/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

00645

Reg. Dist. No. 716

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Chevy Chase, Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yrs

Hospital, Institution, or street address where death occurred:
15 Williams Lane

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Monty

City or town: Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)

Street No. 15 - Williams Lane
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME John H. Gallatin

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mollie Gallatin

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): June 30 1862

8. AGE: Years	Months	Days	If less than one day
82	7	1	....hrs. ....min.

9. Birthplace: Pennsylvania
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Farming

FATHER
12. Name: Franklin Gallatin
13. Birthplace: Penna

MOTHER
14. Maiden name: Elizabeth Ann Strayer
15. Birthplace: Penna

16. Informant: Mrs. Edna J. Smoke

Address: 15 Williams Lane - Chevy Chase Md

17. Removal (Burial, cremation, or removal. Which?) Date thereof Feb. 2, 1945 (month) (day) (year)

Cemetery or crematory: —

Location: Annville, Pa.

18. Funeral director: The S. E. Heisey Co

Address: 2901 - 14 N-W.

19. 1/31 1945 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 31 1945 at 10:30 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1944 to Jan 31 1945

and that I last saw him alive on Jan 31 1945

Immediate cause of death	DURATION
Coronary occlusion	duration unknown
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Frank J. Bonsall M.D.
Dr. Wm. E. Evans M. D. or other

Address: Gettysburg, Pa. Date signed 2-1-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

00646

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years
Hospital, institution, or street address where death occurred:
Home 9508 Singleton Dr.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town 9508 Singleton Dr.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Bethesda, Md.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Elizabeth Gary.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

8.(b) Name of husband or wife Wesley T.
8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 23, 1881

8. AGE:

Years	Months	Days	If less than one day
64	0	2	..... hrs. ..... min.

9. Birthplace Washington, D.C. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name William Henry Kidwell
13. Birthplace Wash. D.C.

MOTHER
14. Maiden name Louisa Kraft
15. Birthplace Maryland.

16. Informant Wesley T. Gary
Address 9508 Singleton Dr.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/27/45 (month) (day) (year)
Cemetery or crematory Cedar Hill Cemetery
Location Maryland
18. Funeral director Wm Reuben Pumphrey
Address 7557 Wis. Ave. Bethesda, Md
19. 1/26 1945 Wm E Jobes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 25 1945 at 3:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 18 1943 to Jan 25 1945 and that I last saw h.e.r alive on 3/31/44 1945

Immediate cause of death	DURATION
Acute Coronary Occlusion	10 min.
Due to Coronary arteriosclerosis	years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Paul D Canton MD
M. D. or other
Address 7425 Wisconsin Date signed 1/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (72-d)

CERTIFICATE OF DEATH

00647

Reg. Dist. No. 214

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Montgomery
City or town Silver Springs Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 809 Sligo Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Roberta M. Glover

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Divorced

6.(b) Name of husband or wife Joseph B Glover

Aug. 24 1871 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
73	4	11	hrs. min.

9. Birthplace D.C. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Own home

FATHER
12. Name William F. Pope
13. Birthplace D.C.

MOTHER
14. Maiden name Annie M. O'Neal
15. Birthplace D.C.

16. Informant Miss Ada F Pope
Address 4515 Grant Rd. N.W.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 8 1944 (month) (day) (year)
Cemetery or crematory Holy Rood
Location Washington D.C.
18. Funeral director Warren E Pumphrey
Address Silver Spring, Md.

19. Jan 5 1945 (Date rec'd by registrar) Josephine M Schaaffe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 5 1945 at 6:50 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 5 1944 to January 5 1945 and that I last saw h.. alive on Jan. 5 1945

Immediate cause of death	DURATION
Congestive Heart Failure	2 hours
Due to Chronic Interstitial Myocarditis	6 months
Due to	
Other conditions Arterial Hypertension	6 months

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. S. Howlett M.D. M. D. or other
Address 928 Sligo Ave. Silver Spring Md. Date signed Jan. 5, 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (472) K

00648

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 days

Hospital, institution, or street address where death occurred: Washington Sanitarium & Hospital

How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: District of Columbia County:

City or town: Washington (If outside city or town limits, write RURAL and give nearest town)

Street No. 249 Carroll St. (If rural, give LOCATION)

2.(a) If veteran, name war: V

3. (a) FULL NAME: Mrs. Sadie Goldberg

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white-Jewish	V

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 20, 1893

8. AGE: Years	Months	Days	If less than one day
51		22	hrs. min.

9. Birthplace: Lithuania (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: own home

FATHER — 12. Name: —

FATHER — 13. Birthplace: —

MOTHER — 14. Maiden name: —

MOTHER — 15. Birthplace: —

16. Informant: Sanitarium Records

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1 11 45 (month) (day) (year)

Cemetery or crematory: New York

Location: N.Y.

18. Funeral director: B. Danzansky & Son

Address: 3501-14th St. N.W. Wash. D.C.

19. Jan 11 1945 (Date rec'd by registrar) J. J. Wm Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1/11 1945, at 5:00 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 4 1945, to Jan 11 1945

and that I last saw h[illegible] alive on Jan 10 1945

Immediate cause of death	DURATION
Carcinoma Right Lung	1 yr
Due to	
Due to	
Other conditions: Secondary Anemia Chronic Myocardial Insufficiency	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury — Injured at work? —

23. SIGNATURE: Henry S. Brown M. D. or other

Address: Takoma Park, Md. Date signed 1/11/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

00649

CERTIFICATE OF DEATH

Reg. Diat. No. 223

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs

Hospital, Institution, or street address where death occurred:

24 Montgomery Ave

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Monty

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 24 Montgomery Ave

(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME Edwin Booth Haas

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	single

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 27, 1879

8. AGE: Years	Months	Days	If less than one day
65	3	23	..... hrs. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation Retired lawyer

11. Industry or business

FATHER 12. Name Isaac C. Haas

13. Birthplace Woodstock, Va.

MOTHER 14. Maiden name Rose Daniels

15. Birthplace Jefferson Co., Va.

16. Informant Miss Rose L Haas

Address 24 Montg. Ave., Takoma Park, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 23, 1945 (month) (day) (year)

Cemetery or crematory Rock Creek

Location Washington, D.C.

18. Funeral director Warner E. Pumphrey

Address Silver Spring, Md.

19. Jan 20 1945 (Date rec'd by registrar) J. A. Dudley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 20 1945, at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1944, Med. Exam. Case, 19..., to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary occlusion	Died suddenly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Frank J. Broschart M.D.
Med. Exam.
M. D. or other

Address Gaithersburg, Md. Date signed 1-20-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

00659

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:
County Montgomery Country
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 days
Hospital, institution, or street address where death occurred:
Washington Sanitarium & Hospital
How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State D. C. County
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1415 E-St. S.E.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME Richard Elmer Hancock

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	- Married -

6.(b) Name of husband or wife Gladys B. Hancock
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 12- 1901

8. AGE: Years	Months	Days	If less than one day
44			..... hrs. ..... min.

9. Birthplace Charles County, Md (Town, county, and state)
10. Usual occupation Armature Winder
11. Industry or business Capital Transit Co
FATHER 12. Name Richard Hancock
13. Birthplace —
MOTHER 14. Maiden name —
15. Birthplace —
16. Informant Patient (Hospital Records)
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 31, 1945 (month) (day) (year)
Cemetery or crematory Cedar Hill
Location Suitland, Md
18. Funeral director W. W. Chambers Co.
Address 1400 Chapin St. N.W. Wash.
19. Jan. 28 1945 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 28- 1945 at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 30, 1944 to Jan 28 1945 and that I last saw h[illegible] alive on Jan 27 1945

	DURATION
Immediate cause of death Myocardial insufficiency	48 hrs
Due to Pulmonary edema and hypostasis	48 hrs
Due to Following Subtotal Gastrectomy + excision of gastro-jejunostomy	1-25-45
Other conditions Moderately Adv. Pulm. TB calcified glands. Fatty degeneration of liver	

(Include pregnancy within 3 months of death)

Major findings of operation Obstructing sclerosing Pyloric ulcer; gastro-jejunostomy
Antopsy results Pulm. Edema; Soft myocardium
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Leah N. Calvert M. D. or other
Address 7894 Ga. Ave, Silver Spring Md. Date signed 1-28-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

00651

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 mo, 6 da

Hospital, Institution, or street address where death occurred:

USNH., Bethesda., Md.

How long in hospital or institution? 5 mo., 6 da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Kentucky County:

City or town: Paducah

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2830 Broadway, Paducah, Ky

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: HANK, Oscar Charles Jr., Ens. O-V(S) USNR

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W-US	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 28 Oct 1917

8. AGE: Years	Months	Days	If less than one day
27	2	29	hrs. min.

9. Birthplace: Kentucky (Town, county, and state)

10. Usual occupation: Navy

11. Industry or business:

FATHER — 12. Name: Oscar C. Hank, Sr.

13. Birthplace: Kentucky

MOTHER — 14. Maiden name: Inez Trent

15. Birthplace: Kentucky

18. Informant: Fa: Oscar C. Hank, Sr.

Address: 2830 Broadway, Paducah, Ky

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 1-8-45 (month) (day) (year)

Cemetery or crematory:

Location: Paducah, Ky.

18. Funeral director: W. W. Chambers Wm MacLean

Address: 1400 Chapin St. N.W., Wash, D.C.

19. 1-8-45 (Date rec'd by registrar) 19 45 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 7 19 45, at 10:03 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 31 July, 1944 to 7 Jan. 19 45 and that I last saw h. alive on 7 Jan. 19 45

Immediate cause of death	DURATION
a. Carcinomatosis of Colon	1½ yrs.
Due to: Fistulation	4 mo.
Due to: Chronic wasting	8 mo.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Recurrent Carcinoma of Colon t mesocolon Tone Date of op. Dec. 15, 1944

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank Edward Smith Jr. M. D. or other

Address: US N.H., Bethesda, Md. Date signed: 1-8-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83)

00652

CERTIFICATE OF DEATH

Reg. Dist. No. 716

1. PLACE OF DEATH:
County: Montgomery
City or town: Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Montgomery
City or town: Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Grace Sanders Haywood

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	W

6.(b) Name of husband or wife: Reuben C. Haywood
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Mar. 5 1874

8. AGE: Years	Months	Days	If less than one day
70			hrs. min.

9. Birthplace: Calif. (Town, county, and State)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Anthony A Sanders
13. Birthplace: Conn.

MOTHER
14. Maiden name: Sarah Ann Field
15. Birthplace: Canada

16. Informant: Miss Ella M. Field
Address: 302 N. Leland St. Chevy Chase

17. Removal (Burial, cremation, or removal. Which?) Date thereof 1-12-45 (month) (day) (year)
Cemetery or crematory
Location
18. Funeral director: The S. H. Hines Co.
Address: 2901 - 14th St. N.W.

19. 1-12-45 (Date rec'd by registrar) 19 [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 12 1945, at 7:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 6 1940, to Jan. 12 1945
and that I last saw h[illegible] alive on Jan. 12 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to: Hypertension	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major fiodiogs of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: E. A. A. Dunn M.D. (M. D. or other)
Address: Bethesda Md. Date signed 1-12-45

(M) (1) MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (37)

CERTIFICATE OF DEATH

00653

Reg. Diat. No. 213

1. PLACE OF DEATH:
County Montgomery
City or town Rockville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
~~Hospital, Institution~~, or street address where death occurred:
108 - North Adams Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 108 - North Adams St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME PRICE Brice Worthington Howard

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) January 6, 1868.

8. AGE: Years	Months	Days	If less than one day
76	11	25	..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Retired
11. Industry or business Farmer
FATHER 12. Name Brice St. Howard
13. Birthplace Maryland
MOTHER 14. Maiden name Catherine Eliza Orndorff.
15. Birthplace Maryland.
16. Informant Miss Eva Howard
Address 108 - N Adams St. Rockville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 4 1945 (month) (day) (year)
Cemetery ~~or crematory~~ St Johns Cemetery
Location Olney, Maryland
18. Funeral director Warner E. Pumphrey
Address Silver Spring, Md.
19. Jan 4 1945 (Date rec'd by registrar) Josephine D. Houlton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 1 1945, at 4.45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 25 1944, to Jan 1 1945 and that I last saw h... alive on Jan 1 1945

Immediate cause of death	DURATION
myocardial degeneration	
& coronary thrombosis	
Due to	
same	
Due to	
—	
Other conditions	
—	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide No Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE W. Ring Shirley M.D. M. D. or other
Address Gaithersburg, Md. Date signed Jan 1, 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

00654

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH

County Montgomery

City or town North Chevy Chase

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mos.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town North Chevy Chase

(If outside city or town limits, write RURAL and give nearest town)

Street No. 9129 Jones Mill Road.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Alice Alberta Hurdle.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife John T. Hurdle.

6.(c) If alive, give age 81 years

7. Birth date of deceased (mo., day, yr.) June 6. 1873

8. AGE: Years 71 | Months 6. | Days 22. | If less than one day ..... hrs. ..... min.

9. Birthplace Washington D. C.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Joshua Tyler

FATHER 13. Birthplace Wash. D.C.

MOTHER 14. Maiden name Unknown

MOTHER 15. Birthplace

16. Informant Margaret Thomas

Address 52. Cattenden St. N.E.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-17-4 (month) (day) (year)

Cemetery or crematory Cedar Hill Cem.

Location Maryland

18. Funeral director Wm Reuben Pumphrey

Address 7557 Wis. Ave. Bethesda

19. 1-15-45 (Date rec'd by registrar) 19..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 14 1945 at 4 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 12 1944 to Jan 14 1945

and that I last saw her alive on Jan 14, 1945

Immediate cause of death	DURATION
(a) Cerebral Hemorrhage	3 hours
Due to (b) Arteriosclerosis	Many years
Due to (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Bradley A Hodgkins M.D.

M. D. or other

Address 313 W Bradley Lane Date signed 1/14/45

Chevy Chase Md

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 63

CERTIFICATE OF DEATH

00655 716

Reg. Dist. No.

1. PLACE OF DEATH:
County: Montgomery
City or town: Chevy Chase, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No. 125 W. Bradley Lane.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mary F. B. Ismirie

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: John Ismirie

If not married, 6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 20 1871

8. AGE: Years 73 | Months 5 | Days 29 | If less than one day: hrs. min.

9. Birthplace: Washington D.C. (Town, county, and state)

10. Usual occupation: Retired housewife

11. Industry or business: Own home

FATHER
12. Name: Frederick A. Bramlett
13. Birthplace: Dawsonville, Md.

MOTHER
14. Maiden name: Mary Feeney
15. Birthplace: New Bedford, Mass.

16. Informant: Mr. John Ismirie
Address: 125 W. Bradley Lane, Chevy Chase

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 22 1945 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Suitland, Md.

18. Funeral director: Warren E. Pumphrey
Address: Silver Spring, Md.

19. 1/19 19 45 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 19 1945 at 4:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 21, 1944 to Jan 19 1945
and that I last saw h alive on Jan 19, 1945

Immediate cause of death	DURATION
Cardiac insufficiency	1 wk.
Due to Chronic cardio-vascular degeneration	3 yrs.
Due to Thyrotoxicosis	15 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: E. G. Bauersfeld M.D. M. D. or other
Address: Bethesda, Md. Date signed: 1-9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

00656

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda Maryland -
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Suburban Hospital -
How long in hospital or institution? Jan. 23 to Jan 24, 1945

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland - County Montgomery
City or town Bethesda -
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7822 Custer Road -
(If rural, give LOCATION)
2.(a) If veteran, name war World War I.

3.(a) FULL NAME Mr. Francis Kavanaugh

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W. Cau.	M.

6.(b) Name of husband or wife Mrs. Frances Kavanaugh -
6.(c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) January 28 1896

8. AGE: Years 48 | Months | Days | If less than one day hrs. min.

9. Birthplace Elmira N.Y. (town, county, and state)
10. Usual occupation Retired veteran
11. Industry or business —
FATHER 12. Name James Kavanaugh -
13. Birthplace Elmira N.Y.
MOTHER 14. Maiden name Mary Mc Hilary -
15. Birthplace Elmira N. York
16. Informant Sister-in-law (Mrs Kavanaugh -
Address 7822 Custer Road -
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/27/45 (month) (day) (year)
Cemetery or crematory St. Marys Cemetery
Location Washington D.C.
18. Funeral director Wm Aloysius Humphrey
Address 7557 Wis. Ave. Bethesda Md
19. 1-26-45 19.. (Date rec'd by registrar) M D Jones md Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 24 19 45, at 12:15 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 23 1945, to January 24 1945
and that I last saw h.. alive on January 24 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	8 hours
Cardiac Arrhythmia	1 hr.
Due to Generalized Arteriosclerosis	3-4 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op.
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide No Date of No
Where did injury occur? No (City or town) No (County) No (State)
Injured at home, farm, industry, public place (where?) No
Means of injury Injured at work?

23. SIGNATURE I.O.B. Wardrop M.D. M. D. or other
Address 943 Bonifant St. Silver Spring Md Date signed Jan 24, 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

00657

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, Md. (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? nine days

Hospital, institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Md.

How long in hospital or institution? nine days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4007 21st St. N. E.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: KELLEY, Olive Mildred

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	W-US	married

6.(b) Name of husband or wife: Maj. Michael J. Kelley, USMCR

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): April 17, 1894

8. AGE: Years	Months	Days	If less than one day
50	9	06	..... hrs. ..... min.

9. Birthplace: Mass.
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business:

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: husband: Maj. Michael J. Kelley
Address: 4007 21st St. N. E., Wash., D.C.

17. removal (Burial, cremation, or removal. Which?) Date thereof 1-24-45 (month) (day) (year)

Cemetery or crematory:

Location:

16. Funeral director: W. K. HUNTMANN (MTE)
Address: 5732 Georgia Avenue, N. W. Wash., D.C.

19. Jan 24 19 45 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 23 19 45 at 8:40p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 14 19 45, to Jan 23 19 45 and that I last saw h... alive on Jan 23d 19 45

Immediate cause of death	DURATION
Cerebral Hemorrhage	12 Hours
on basis of Aplastic Anemia	12 Days
Due to from Probable Arsenicals	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: Not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Gordon R. Lamb St. Cmdr. M. D. or other

Address: USNH Bethesda, Md. Date signed: Jan 24, 45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-D)

00658

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH: 208 Williamsburg Drive.
County ..... Silver Spring Md.
City or town ..... (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 yrs 5 mos
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md. County Montgomery
City or town Indian Spring (If outside city or town limits, write RURAL and give nearest town)
Street No. 208 - Williamsburg Dr. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mary Ellen Keppel

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fe.	White	married (widowed)

6.(b) Name of husband or wife Timothy A Keppel
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 20 - 1870

8. AGE: Years 74 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace New York City N Y (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name P Roche
13. Birthplace ~~Unknown~~ Ireland

MOTHER
14. Maiden name unknown
15. Birthplace Ireland

16. Informant Mrs Mildred Ludwig
Address 208 Williamsburg Dr.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 6 - 1945 (month) (day) (year)
Cemetery or crematory Mt Olivet
Location Bladensburg Rd - Wash. D.C.

18. Funeral director The S H Hines Co
Address 2901 - 14th St NW

19. Jan 4 19 45 Josephine M. Schaeffer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jany 3 1945 at 5:50 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1943 to Jany 3 1945 and that I last saw h.. alive on Jany 1 1945

Immediate cause of death Cancer of uterus — DURATION 3 years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE John N. Andrews M.D. M. D. or other
Address Silver Spring Md Date signed 1-3-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1902

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00659

Reg. Diat. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Suburban Hospital
How long in hospital or institution? 2 mos - 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 417 Pershing Drive
(If rural, give LOCATION)
2.(a) If veteran, name war World War #1

3.(a) FULL NAME Carl Koch

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Lottie
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Apr-10, 1894

8. AGE: Years	Months	Days	If less than one day
50	9	7	..... hrs. ..... min.

9. Birthplace Brooklyn N.Y.
(Town, county, and state)
10. Usual occupation Examiner
11. Industry or business R.F.C.
FATHER 12. Name KARL A. Koch
13. Birthplace GERMANY
MOTHER 14. Maiden name Dorothea Gaeger
15. Birthplace GERMANY.
16. Informant Mrs Lottie C Koch
Address 417 Pershing Drive Silver Spring
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 20 45 (month) (day) (year)
Cemetery or crematory Arlington National
Location Arlington Co - Va
18. Funeral director Wood E Pumphrey
Address 8434 Ga Ave - Silver Spring - Md
19. 1/19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan - 17, 1945, at 9 55 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 11 1944, to January 17 1945
and that I last saw h in alive on January 17 1945

Immediate cause of death	DURATION
Cardiac Decompensation	1 Month
Due to Coronary Thrombosis	2 Months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE I O Blanding MD
M. D. or other
Address 943 Bonifant St. Date signed 1/21/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 86-a

CERTIFICATE OF DEATH

00660

Reg. Dist. No. 217

1. PLACE OF DEATH:

County Montgomery

City or town Olney, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital Inc.

How long in hospital or institution? 11 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Brinklow

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Miss Harriet Iddings Lea

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single.

6.(b) Name of husband or wife —

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 5, 1845

8. AGE: Years 99 | Months 7 | Days 5 | If less than one day ... hrs. ... min.

9. Birthplace Sandy Spring, Montg. Co., Md. (Town, county, and state)

10. Usual occupation —

11. Industry or business —

MOTHER FATHER

12. Name Thomas Lea

13. Birthplace Wilmington, Delaware

MOTHER

14. Maiden name Beulah Iddings

15. Birthplace Philadelphia, Penna.

16. Informant Hospital records.

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof January 12, 1945 (month) (day) (year)

Cemetery or crematory Wood Side

Location Brinklow Maryland

18. Funeral director Roy W. Barber

Address Laytonsville Md

19. Jan 12 1945 Gertrude B. Lauck (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 10 1945, at 3:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 30 — 1944 to January 10 1945

and that I last saw h.e.r. alive on January 10 1945

Immediate cause of death	DURATION
General debility	2 years
Due to associated with	
fracture of femur	11 days
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of Dec 30-44

Where did injury occur? In own room (City or town) Dalecarlia (County) Mont (State) Md.

Injured at home, farm, industry, public place (where?)

Means of injury fell in own room Injured at work? —

23. SIGNATURE Chas B Tumbleson M. D. or other

Address Sandy Spring, Md Date signed 1/10/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (177-B)

00661

CERTIFICATE OF DEATH

Reg. Dist. No. 2/2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Poolesville, Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Hours

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Montgy

City or town: Poolesville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Richard Wade Leith

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec. 26-1926

8. AGE:

Years	Months	Days	If less than one day
18	11	22	hrs. min.

9. Birthplace: Broad Run, Va. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER

12. Name: Albert Leith

13. Birthplace: Va.

MOTHER

14. Maiden name: Mary Lee Leith

15. Birthplace: Va.

16. Informant: Albert Leith

Address: Poolesville, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof 1/20/45 (month) (day) (year)

Cemetery or crematory: Middleburg Cem.

Location: Middleburg Va.

18. Funeral director: William B. Holtzman

Address: Barnesville, Md.

19. Jan. 19 1945 (Date rec'd by registrar) Charles E. Elgin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 18, 19 45, at 4:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 18 to Jan. 18 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Asphyxia	2nd day
Due to: Carbon monoxide poisoning (accidental)	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accidental Date of Jan. 18 45

Where did injury occur? Poolesville (City or town) Montg. (County) Md. (State)

Injured at home, farm, industry, public place (where?) Farm-dead in car

Means of injury Injured at work?

Frank J. Bronstad M.D.

23. SIGNATURE: Dep. Med. Exam. M. D. or other

Address: Gaithersburg, Md. Date signed 1-18-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1)

00662

CERTIFICATE OF DEATH

Reg. Dist. No. 215

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH: Montg Co,

County .....

City or town Clarksburg Md (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20yrs

Hospital, institution, or street address where death occurred:

.....

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montg

City or town Clarksburg Md
(If outside city or town limits, write RURAL and give nearest town)

Street No. .....
(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME Maud Getzendiner Linthicum Linthicums

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife George Best Linthicum

6.(c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) Sept 29th 1886

8. AGE: Years	Months	Days	If less than one day
1886 58	3	10	..... hrs. ..... min.

9. Birthplace Frederick Co. Md.
(Town, county, and state)

10. Usual occupation House Wife

11. Industry or business " "

FATHER
12. Name William Getzendiner
13. Birthplace Md,

MOTHER
14. Maiden name Bell Remsburg
15. Birthplace Md

16. Informant George Best Linthicum
Address Clarksburg Md,

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/12/45 (month) (day) (year)

Cemetery or crematory Mt Olivet Cemetery

Location Frederick Md,

18. Funeral director C E CLINE

Address Frederick Md,

19. Jan 10 1945 (Date rec'd by registrar) Alanda G Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 9 1945, at 5:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1941, to Jan 9 1945

and that I last saw h.e.m. alive on Jan 9 1945

Immediate cause of death	DURATION
Uremia	2 days
Due to Chronic cardio-renal disease	3 yrs
Due to Hypertension	4 yrs
Other conditions diabetes	10 yrs

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE H. J. Brosehart M D.
M. D. or other

Address Gaithersburg Md Date signed 1-10-45

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(1) MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

00663

Reg. Dist. No. .....

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? .....
Hospital, Institution, or street address where death occurred:
on Street, 505 Park Lane
How long in hospital or Institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Monty.
City or town Bethesda, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 115 West Glenbrook Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3. (a) FULL NAME David Lumsden

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife Sarah Jane
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 21, 1871

8. AGE: Years	Months	Days	If less than one day
73			..... hrs. ..... min.

9. Birthplace England (Town, county, and state)
10. Usual occupation Retired Horticulturist
11. Industry or business .....

FATHER
12. Name David Lumsden
13. Birthplace Scotland

MOTHER
14. Maiden name Mary Allen
15. Birthplace England

18. Informant Ed. L. Duffies
Address 4532, 19th St. Arlington Va.

17. Burial Date thereof 1/24/45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Fort Lincoln Cem.
Location Maryland

18. Funeral director Wm. Reuben Sumphrey
Address 7557 Wis. Ave. Bethesda Md.

19. 1/23 1945 Wm E. Jobes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 21, 1945, at 6 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 7 1944 to Jan 21 1945 and that I last saw him alive on Jan 21, 1945

Immediate cause of death	DURATION
Coronary occlusion	1 day
Due to Chr. cardio. vascular	10 yrs.
Due to disease.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE E. L. Bauserfeld M.D.
M. D. or other
Address Bethesda, Md. Date signed 1/22/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

CERTIFICATE OF DEATH

00664

Reg. Dist. No. 443

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Washington Sanitarium Hospital

How long in hospital or institution? 2 yr 8 mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5826 Nevada Ave N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Donald Lloyd Lunsford

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Pauline Gibb Lunsford

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 13, 1889

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
55	8	7		

9. Birthplace: Manistee, Michigan (Town, county, and state)

10. Usual occupation: Real Estate

11. Industry or business: own

FATHER — 12. Name: Albert Lunsford

13. Birthplace: Sussex county, England

MOTHER — 14. Maiden name: Celia Margaret Lloyd

15. Birthplace: Muskegon, Michigan

16. Informant: Records, which have Hospital

Address: Takoma Park, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Jan 20-1945 (month) (day) (year)

Cemetery or crematory:

Location: Washington D.C.

18. Funeral director: The S H Hines Co.

Address: 2901 - 14th St NW

19. Jan 20 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 20 1945, at 4:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1943, to Jan. 20 1945.

and that I last saw him alive on Jan. 19. 1945.

Immediate cause of death	DURATION
Acute Nephritis	Terminal
Due to: Nephrosclerosis	2 Years
Due to: Arteriosclerosis (General)	Years.
Other conditions: Hypertension	year

(Include pregnancy within 3 months of death)

Major findings of operations: X

Date of op.:

Autopsy results: X

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert A Hare M.D.

M. D. or other

Address: Takoma Park Md. Date signed: 1/20/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (163-CB)

CERTIFICATE OF DEATH

00665

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 hours
Hospital, institution, or street address where death occurred:
USNAVAL HOSPITAL, Bethesda, Md.
How long in hospital or institution? 2 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town: Washington, D. C.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 36 Longfellow St., N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: LUYSTER, Arnold Burton, CPhM USN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 21 June 1918

8. AGE: Years	Months	Days	If less than one day
26	7	08	hrs. min.

9. Birthplace: Mo.
(Town, county, and state)

10. Usual occupation:

11. Industry or business: Navy

FATHER
12. Name: Aloyzo Bowers Luyster
13. Birthplace: Linneus, Mo.

MOTHER
14. Maiden name: Della Sayers
15. Birthplace: Linneus, Mo.

16. Informant: Wife: Mrs. Arnold B. Luyster
Address: 417 East Colton Avenue, Redlands, Calif.

17. burial — Date thereof: 2-3-45 (month) (day) (year)
(Burial, cremation, or removal. Which?)
Cemetery or crematory: Arlington National
Location: Arlington, Va.

18. Funeral director: W.W. Chambers, 1400 Chapin St.
Address: Washington, D. C.

19. Jan 31 1945 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 29 19 41, at 12:42 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep. Med. Exam 19 to 19
and that I last saw h alive on 19
Cause

Immediate cause of death	DURATION
aspiration asphyxia	2 hrs
Due to: vomitus	2 hrs
Due to: Barbiturate	2 hrs
Other conditions	

(Incinde pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: suicide Date of: 1-29-45
Where did injury occur? Washington, D. C.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Frank J. Bronhart M.d.
Dep Med. Exam. M. D. or other
Address: Washington, D.C. Date signed: 1-30-41

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30)

CERTIFICATE OF DEATH

00665

Reg. Dist. No. 213

1. PLACE OF DEATH:

County: Monty

City or town: Rockville (outside)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 mo.

Hospital, institution, or street address where death occurred:
—

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Monty

City or town: Rockville (outside)
(If outside city or town limits, write RURAL and give nearest town)

Street No. Glen Road, Potomac, Md
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Elizebeth K Lytle (LYTLE)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	White	Widow

6.(b) Name of husband or wife: Wm Douglas Lytle

6.(c) If alive, give age: Dec 16 (years)

7. Birth date of deceased (mo., day, yr.): Dec. 23, 1860.

8. AGE:

Years	Months	Days	If less than one day
85	0	17	...hrs. ...min.

9. Birthplace: Glasgow Scotland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: —

FATHER
12. Name: Alexander Kennedy
13. Birthplace: Town not known Scotland

MOTHER
14. Maiden name: Janet Barr Kennedy
15. Birthplace: Glasgow Scotland

16. Informant: Graham Lytle
Address: Glen Road, Potomac, Md

17. Cremation (Burial, cremation, or removal. Which?) Date thereof Jan 10-11 '45 (month) (day) (year)

Cemetery or crematory: ~~Gawler's~~ Cedar Hill

Location: Prince Geo. Co. ~~West of~~ Suitland, Md

18. Funeral director: Jos. Gawler's Sons

Address: 17th & Penn Ave. N.W. Wash DC.

19. 1/10 1945 (Date rec'd by registrar) Josephine D. Wootton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 10 1945 at 2:00 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1944 Med. Exam Care 19... to ... 19...

and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death: Cerebral hemorrhage	Four days
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Frank J. Broschart M.D. M. D. or other

Address: Gaithersburg Md Date signed 1-10-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-E)

00667

CERTIFICATE OF DEATH

Reg. Diat. No. 28

1. PLACE OF DEATH:
County Montgomery
City or town Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 year
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6- Brooke Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Virginia Catherine Mainhart

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife Bruce R. Mainhart
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct - 21 - 1915

8. AGE: Years	Months	Days	If less than one day
29	2	30	— hrs. — min.

9. Birthplace Portsmouth Va.
(Town, county, and state)
10. Usual occupation at home
11. Industry or business keeping house

FATHER
12. Name William C. Lee
13. Birthplace Portsmouth Va.

MOTHER
14. Maiden name Julia L. Barrett
15. Birthplace Portsmouth Va.

16. Informant Bruce R. Mainhart
Address Gaithersburg, Md.

17. Burial Date thereof 1/23/45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Forest Oak Cemetery
Location Gaithersburg Md.

18. Funeral director Wm Paulk Humphrey
Address 7557 Wis. Ave. Bethesda, Md.

19. Jan 24 1945 Alvadar L Cook
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January - 20 - 1945 at 7:20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
— 19 36 to January 20 19 45
and that I last saw her alive on January - 19 - 19 45

Immediate cause of death	DURATION
Myocardial insufficiency	9 yrs
Due to Mitral insufficiency	9yrs +
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE William C. Miller M.D.
M. D. or other
Address Gaithersburg, Md. Date signed 1/31/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-01)

CERTIFICATE OF DEATH

00668

Reg. Dist. No. 716

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Montgomery

City or town Chevy Chase Md
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution 318 Hight st

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Chevy Chase Md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 318 High st
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mary J. McAuliffe

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife John D.

6(c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) March 6 - 1876

8. AGE: Years 68 | Months | Days | If less than one day ____ hrs. ____ min.

9. Birthplace Ireland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name John O'Connor

13. Birthplace Ireland

MOTHER 14. Maiden name Mary Griffin

15. Birthplace Ireland

16. Informant Mrs Mary C. Kane

Address 318 High st

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 18, 1945 (month) (day) (year)

Cemetery or crematory Mt Olivet

Location Washington D. C.

18. Funeral director Albert Ashe

Address 641 - 4th - N.E. Wash. D.C.

19. 1-15-45 (Date rec'd by registrar) 19____ W E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 15 1945, at 12:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 5 1945, to Jan. 15 1945, and that I last saw h-- alive on Jan. 14 1945.

	DURATION
Immediate cause of death Congestive Heart Failure	10 days
Due to Coronary Thrombosis	24 hrs
Due to Carcinoma-prostate with renal disease	5 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Sidney L. Lousime M.D.
M. D. or other

Address 3921 Livingston St. N.W. Date signed 1/15/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00669

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1947 - Capital View Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Hugh Edward McNealy

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Sadie Virginia
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec 14 - 1905

8. AGE: Years: 39 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Ryan Va (Town, county, and state)

10. Usual occupation: Radio Technician

11. Industry or business

FATHER
12. Name: Maurice B McNealy
13. Birthplace: Ashbourne Va

MOTHER
14. Maiden name: Estelle Croson
15. Birthplace: Fairfax Va

16. Informant: Sadie Va McNealy
Address: 1947 - Capital View Ave

17. Burial, cremation, or removal. Which?: Removal
Date thereof: Jan 12 1945 (month) (day) (year)
Cemetery or crematory: Burned Fort Lincoln
Location: Wash. D.C.

18. Funeral director: The S.H. Hines Co
Address: 2901 - 14th St NW

19. Jan. 10 1945 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 9 1945 at 4 40 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 18 1944 to Jan 9 1945 and that I last saw him alive on Jan 9 1945

Immediate cause of death	DURATION
Asthenia	
Due to Metastatic Carcinoma (generalized)	6 mos.
Due to Adeno Carcinoma (rectum)	1 year
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Adeno. carcinoma (rectum)
Date of op. Apr. 13, 1944
Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Hubert H Schonfeld M. D. or other
Address: 1726 Eye St., N.W. Date signed: 1/9/45

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00670

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:
County: Montgomery
City or town: Gaithersburg (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 hours
Hospital, institution, or street address where death occurred: ✓
How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Gaithersburg (If outside city or town limits, write RURAL and give nearest town)
Street No.: Route - 3 (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME David Lee Miller

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife: ✓
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January - 3 - 1945

8. AGE:

Years	Months	Days	If less than one day
0	0	0	5 hrs. 0 min.

9. Birthplace: Gaithersburg, Md. (Town, county, and state)
10. Usual occupation: none
11. Industry or business: ✓

FATHER
12. Name: Thomas Hoyt Miller
13. Birthplace: Rio, W. Va.

MOTHER
14. Maiden name: Jannie Pearl Reynolds
15. Birthplace: Rio, W. Va.

16. Informant: Jannie Pearl Miller
Address: Gaithersburg, Md. R-3

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 4, 1945 (month) (day) (year)
Cemetery or crematory: Hasson Hill
Location: Redland Md

18. Funeral director: Thomas Hoyt Miller
Address: Redland. Md.

19. Jan. 4 1945 (Date rec'd by registrar) Alsada L. Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January - 4 - 1945 at 4 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January - 3 - 1945 to January - 4 - 1945 and that I last saw him alive on January - 3 - 1945.

Immediate cause of death	DURATION
Congenital heart disease	5 hours
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: William C. Miller, M.D. M. D. or other
Address: Gaithersburg, Md. Date signed 1 - 4 - 45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-d)

CERTIFICATE OF DEATH

00671

Reg. Dist. No. 217

1. PLACE OF DEATH:

County Montgomery

City or town Fairland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Fairland

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Joseph T. Milstead.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife Bertha Briggs Milstead

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August 13, 75

8. AGE:

Years	Months	Days	If less than one day
69	4	26	..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation None

11. Industry or business Retired Farmer.

FATHER

12. Name Joseph T. Milstead

13. Birthplace md.

MOTHER

14. Maiden name Julia Nash

15. Birthplace Md.

16. Informant Wife.

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-11-45 (month) (day) (year)

Cemetery or crematory Burtonsville Union

Location Burtonsville Md.

18. Funeral director Wm Reuben Pumphrey

Address Bethesda Maryland

19. Jan 10 1945 (Date rec'd by registrar) Gertrude B. Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 9 1945, at 7 30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 2 1944, to Jan. 9 1945

and that I last saw him alive on December 2, 1944

Immediate cause of death	DURATION
Acute Cardiac Dilatation	1 day
Due to Chronic Myocarditis	1 year.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J M B [illegible] M.D.

M. D. or other

Address Sandy Spring - Md Date signed 1/9/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-E)

CERTIFICATE OF DEATH

2455

00672

Reg. Diat. No. 218

1. PLACE OF DEATH

County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Suburban Hospital

How long in hospital or institution? 32 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Monrovia

(If outside city or town limits, write RURAL and give nearest town)

Street No. R 7 D #2

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Everet Monroe Motley

3.(b) Social Security Number 578-16-1372

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Margaret

6.(c) If alive, give age: 30 years

7. Birth date of deceased (mo., day, yr.): Aug 19, 1913

8. AGE: Years: 31 | Months: 5 | Days: 10 | If less than one day: hrs. min.

9. Birthplace: Frederick Co. Md. (Town, county, and state)

10. Usual occupation: Policeman

11. Industry or business

FATHER 12. Name: Everet Motley

13. Birthplace: Montgomery Co. Md.

MOTHER 14. Maiden name: Lillian Williams

15. Birthplace: Neelsville, Md.

16. Informant: wife

Address: same

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 1 - 1945 (month) (day) (year)

Cemetery or crematory: Montgomery Chapel

Location: Clopperville Md

18. Funeral director: Ray W Barber

Address: Kensington Md

19. 1/30/45 (Date rec'd by registrar) L. J. Bell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan - 29, 1945, at 3:16 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 19 to Jan 19

and that I last saw h alive on 19

	DURATION
Immediate cause of death: Shock	1 hr
Due to: Fracture of 3rd dorsal vertebrae	1½ hrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accidental Date of: 1-29-45

Where did injury occur? Baltimore (City or town) Md (County) (State)

Injured at home, farm, industry, public place (where?): highway

Means of injury: auto accident Injured at work? No

23. SIGNATURE: Frank J. Brockhurst M.D. M. D. or other

Address: Baltimore Md Date signed: 1-29-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

00673

Reg. Diat. No. 211

1. PLACE OF DEATH:
County Montgomery
City or town Clagettsville R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? All Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME Minnie Jane Mosley

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Widowed

6.(b) Name of husband or wife Willis B. Mosley
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 14 - 1870

8. AGE:

Years	Months	Days	If less than one day
74	10	4	hrs. min.

9. Birthplace Montgomery Co. Md.
(Town, county, and state)
10. Usual occupation Domestic
11. Industry or business Farm
12. Name of FATHER William C. Bellison
13. Birthplace of FATHER Montgomery Co. Md.
14. Maiden name of MOTHER Minnie Wrighter
15. Birthplace of MOTHER Baltimore Md.
16. Informant Virgie Mosley
Address Monrovia Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 19-1945 (month) (day) (year)
Cemetery or crematory Montgomery
Location Clagettsville Md.
18. Funeral director Roy W. Barber
Address Laytonsville Md.
19. Jan 19 1945 (Date rec'd by registrar) Della V. Burdette Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 17 1945, at 12:20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to Jan 17, 1945
and that I last saw h.. alive on January 15 1945

Immediate cause of death	DURATION
Uremia	1 wk
Due to Cerebral Hemiplegia	2 wks
Due to Arteria - Sclerosis	yrs?
Other conditions Chr. Hypertension	yrs?

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. Stanley Grabill M. D. or other
Address Mt. Airy, Md. Date signed 1/18/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94-a)

00674

CERTIFICATE OF DEATH

Reg. Diat. No. 723

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Died while driving

Hospital, institution, or street address where death occurred: automobile

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State ~~Md~~ D.C. County ~~Mont~~ District of Columbia

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6701 Piney Branch Rd

(If rural, give LOCATION)

2.(a) If veteran, name war World War I ✓

3.(a) FULL NAME Raymond B Murray

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Helen J. Murray

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years 48 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Rockville, Hartford Co. Conn. (Town, county, and state)

10. Usual occupation Director Army Motion Picture Service

11. Industry or business

FATHER 12. Name Francis Murray

13. Birthplace

MOTHER 14. Maiden name Information not available

15. Birthplace

16. Informant Raymond B. Murray, Jr.

Address 6701 Piney Branch Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-8-45 (month) (day) (year)

Cemetery or crematory Arlington National

Location Arlington Va

18. Funeral director Francis Collins

Address 3821-14th St. NW Wash. D.C.

19. Jan 3 1945 (Date rec'd by registrar) J. Wm Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 3 19 45, at 6:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep. Med. Exam. 19 ..... to ..... 19 .....

and that I last saw h..... alive on ..... 19 .....

Immediate cause of death ..... DURATION

Coronary occlusion ..... died suddenly

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Frank J. Broschart M.D. M. D. or other

Address Dep. Med. Exam. Rockville Md Date signed 1-3-45

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-7)

00675

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24 hours
Hospital, Institution, or street address where death occurred:
U. S. NAVAL HOSPITAL, Bethesda, Md.
How long in hospital or institution? 24 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Va. County: Arlington
City or town: Arlington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1007 26th Road, So., Arlington, Va.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: MUSBACH, William Frederick, Lt.(jg) (SC) (S) USNR

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mrs. Audrey Musbach
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 14 September 1912

8. AGE: Years	Months	Days	If less than one day
32	2	6	..... hrs. ..... min.

8. Birthplace: Wis. (Town, county, and state)
10. Usual occupation: Supply Corps
11. Industry or business: Navy

FATHER
12. Name: Frederick Musbach
13. Birthplace: Wisc. (deceased)

MOTHER
14. Maiden name: Roxena Billings
15. Birthplace: Wis. (deceased)

16. Informant: Wife: Mrs. Audrey Musbach
Address: 1007 26th Road, So., Arlington, Va.

17. cremation (Burial, cremation, or removal. Which?) Date thereof 1-24-45 (month) (day) (year)
Cemetery or crematory:
Location:

18. Funeral director: W. W. Chambers Kmy
Address: 1400 Chapin St., N. W., Wash., D. C.

19. 1-21- 1945 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 21 1945 at 12 50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 20 1944 to Jan 20 1945 and that I last saw him alive on Jan 21 1945

Immediate cause of death	DURATION
Respiratory failure	2 years
Due to: Metastatic Malignant Melanoma -	
Due to: Liver and generalized metastasis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Malignant Melanoma - Date of op.
Autopsy results: Metastatic Malignant Melanoma
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: J. C. Binkley MC USNR M. D. or other
Address: USNH Bethesda, Md. Date signed 1-22-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

00676

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Dist. No. 143

1. PLACE OF DEATH:
County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 Months
Hospital, institution, or street address where death occurred: 604 ~~Long branch Parkway~~ FLOWER AVE.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 318 Long branch Parkway
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: VICTOR Nelson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Martha Nelson.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1883.

8. AGE: Years: 61 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Sweden (Town, county, and state)

10. Usual occupation: Cook

11. Industry or business:

FATHER
12. Name: unknown
13. Birthplace: Sweden

MOTHER
14. Maiden name: Unknown
15. Birthplace: Sweden

16. Informant: Mrs. R. H. Hanson
Address: 114 Melbourne Ave. Silver Spring, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 29 1945 (month) (day) (year)
Cemetery or crematory: Geo. Wash. Memorial Cemetery
Location: Fairview Rd. Hyattsville, Md.

18. Funeral director: Arthur Stallings.
Address: 254

19. Jan 27 1945 (Date rec'd by registrar) J. Elton Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 26 1945, at 4:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 26 Med. Exam 1945 to Date 1945
and that I last saw h... alive on 1945

Immediate cause of death	DURATION
Coronary occlusion	died suddenly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (Coooty) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank J. Brosnan M.D.
Dep. Med. Exam. M. D. or other
Address: Gaithersburg Md. Date signed 1-26-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23-a)

00677

CERTIFICATE OF DEATH

Reg. Diat. No. 214

1. PLACE OF DEATH:
County: Montgomery
City or town: Kensington
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2½ years
Hospital, institution, or street address where death occurred:
9 Pearson St.
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Montgomery
City or town: Kensington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 9 Pearson
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: John Thomas Norris

3.(b) Social Security Number: 577-10-7353

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Florence Ritter Norris
6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): Nov. 8, 1872

8. AGE: Years	Months	Days	If less than one day
72	1	29	...hrs. ...min.

9. Birthplace: Poolesville Md.
(Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: —

FATHER
12. Name: John Thomas Norris
13. Birthplace: Montgomery County Md.

MOTHER
14. Maiden name: Margaret Ann King
15. Birthplace: Md.

16. Informant: Mrs. J. T. Norris
Address: 9 Pearson St. Kensington, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Jan 10-45 (month) (day) (year)
Cemetery or crematory: Oak Hill Cem
Location: Washington
18. Funeral director: The S.T. Hines Co
Address: 2901-14th St N W

19. Jan. 7 1945 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 6 1945 at 10:30 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ...1942, to Jan 6 1945
and that I last saw h... alive on Jan 6 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	4 days
Due to: Hypertension	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: J. Marion Bandroad M.D.
M. D. or other
Address: Silver Spring, Md. Date signed: 1/6/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for change of age of deceased is shown on FILM ...G 93 MAR 20 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

00678

Reg. Dist. No. 21P

1. PLACE OF DEATH:

County: Montgomery

City or town: Brighton Road, Layhill – Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Layhill
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Brigh Road –
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: OBERLIN, BERWYN J.

3.(b) Social Security Number: 578-28-0389

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	SINGLE

6.(b) Name of husband or wife: —

6.(c) If olive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 10, 1916

8. AGE: Years	Months	Days	If less than one day
28 – 29 –	2	10	..... hrs. ..... min.

9. Birthplace: Four Corners, Md.
(Town, county, and state)

10. Usual occupation: Investigator

11. Industry or business: State Loan Co.

FATHER 12. Name: Oberlin, John J.

FATHER 13. Birthplace: Pa.

MOTHER 14. Maiden name: Jacqueline E. Spangler

MOTHER 15. Birthplace: Hackwood, Va.

16. Informant: Norman C. Oberlin

Address: Glenmont, Silver Spring, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 24, 1945 (month) (day) (year)

Cemetery ~~or crematory~~: Colesville Cemetery

Location: Colesville, Md.

18. Funeral director: Warner E. Pumphrey

Address: Silver Spring, Md.

19. Jan. 24 1945 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 20 1945 at 11:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 7 1934, to Jan 20 1945 and that I last saw h.. alive on Dec 14 1944

Immediate cause of death	DURATION
Tuberculosis - pulmonary	10 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W. P. Mitchell M.D. M. D. or other

Address: Silver Spring Md. Date signed 1-21-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

00679

CERTIFICATE OF DEATH

Reg. Dist. No. 2W3

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park - Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Mos.

Hospital, institution, or street address where death occurred:
314 Carroll Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Monty

City or town: Takoma Park -
(If outside city or town limits, write RURAL and give nearest town)

Street No. 314 Carroll Ave.
(If rural, give LOCATION)

2.(c) If veteran, name war

3. (a) FULL NAME

Kalle - Oja.

(Kalle Oja)

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 6 - 1876.

8. AGE: Years	Months	Days	If less than one day
68	6	14	..... hrs. ..... min.

9. Birthplace: Auburn, Finland
(Town, county, and state)

10. Usual occupation: Farmer - Retired.

11. Industry or business

FATHER
12. Name: Kalle Juhana Oja.
13. Birthplace: Finland.

MOTHER
14. Maiden name: unknown
15. Birthplace: Finland.

16. Informant: Taarla Oja.
Address: 314 Carroll Ave. Takoma Park -

17. Burial. Date thereof Jan. 24 1945.
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: George Washington Memorial Cemetery

Location: Riggs Road, Hyattsville, Md.

18. Funeral director: Wilbur Walters

Address: 254 Carroll Ave. Takoma Park D.C.

19. Jan 22 1945 J. H. Am. D.C.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan - 20 1945, at 4:P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1944 to Jan 1945.
and that I last saw h alive on Jan 1945

Immediate cause of death	DURATION
Coronary occlusion	died suddenly
Due to	
Due to	
Other conditions: Bronchial Asthma	2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Fred J. Bronchart M.D.
M. D. or other

Address: Gaithersburg Md. Date signed 1-20-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

00684

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-e)

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 45 hours
Hospital, institution, or street address where death occurred:
U.S. Naval Hospital, Bethesda, Md.
How long in hospital or institution? 45 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Penn. County:
City or town: Greensburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. 351 Concord Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: PETERS, William Willis

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	

6.(b) Name of husband or wife: Mrs. Bertha Ruth Peters
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Feb. 5, 1898

8. AGE: Years	Months	Days	If less than one day
46	10	29	hrs. min.

9. Birthplace: Greensburg, Penn.
(Town, county, and state)
10. Usual occupation: merchant & Bus Agent
11. Industry or business:

FATHER
12. Name: John Peters
13. Birthplace: Greensburg, Pa.

MOTHER
14. Maiden name: Jennie Peters
15. Birthplace: Greensburg, Pa.

16. Informant: Wife: Mrs. Bertha Ruth Stocker
Address: 351 Concord Avenue, Greensburg, Pa.

17. removal (Burial, cremation, or removal. Which?) Date thereof: 1-4-45 (month) (day) (year)
Cemetery or crematory:
Location: Greensburg, Pa.

18. Funeral director: Wm. R. Pumphrey Jr. P.
Address: 7557 Wisconsin Ave., Bethesda, Md.

19. Jan 4 19 45 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 4 19 45, at 4:10 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 31 19 45 to Jan 4 19 45
and that I last saw h alive on 19

Immediate cause of death	DURATION
Basilar Meningeal Hemorrhage	
due to Fracture of Cribiform Plate of Skull	2 days
Due to	
Due to	
Other conditions: Pulmonary Congestion with Pedema	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: same as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accidental Date of: Jan 2 1945
Where did injury occur? Bethesda (City or town) Montg (County) Md (State)
Injured at home, farm, industry, public place (where?): highway
Means of injury: auto. accident Injured at work?

23. SIGNATURE: Frank J. Bouchart M.D.
M. D. or other
Address: Greensburg, Pa. Date signed: 1-4-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-D)

00681

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH:

County: Montg Co.,

City or town: Gaithersburg Md.,
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3Yr 9 Mo,

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montg

City or town: Gaithersburg Md
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Martha Fletcher Pettit

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Zachary Taylor Pettit

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan 23 1853

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
1853 92	0	8		

9. Birthplace: Norfolk. Va,
(Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business: "

FATHER
12. Name: Joseph R Small
13. Birthplace: Va,

MOTHER
14. Maiden name: Eliza Burt
15. Birthplace: Va,

16. Informant: Methodist Home, Rev H M Wilson
Address: Gaithersburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/3/45 (month) (day) (year)

Cemetery or crematory: Washington Congressional Cemetery

Location: Washington, D C,

18. Funeral director: Ernest C Gartner

Address: Gaithersburg Md

19. Feb 1 1945 (Date rec'd by registrar) Abraham L Cook Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 31 1945, at 7.30P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov 1 1944, to Jan 30 1945

and that I last saw h.. alive on Jan 30 1945

Immediate cause of death	DURATION
Stroke of Paralysis	
Due to: Hemorrhage of Brain	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D., or other

Address: Gaithersburg Md Date signed Feb 1 1945

(M) MARGIN RESERVED FOR BINDING (1)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (T)

Evidence for change of age is shown on FILM No G94 MAY 14 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23

CERTIFICATE OF DEATH

00682

Reg. Dist. No. 218

1. PLACE OF DEATH:
County Montgomery
City or town Gaithersburg, Md. R.7 D3
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Gaithersburg, R. 7. D. 3
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Harriett A. Plummer

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	married

6.(b) Name of husband or wife George W. Plummer
6.(c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) Aug. 30. 1879

8. AGE: Years	Months	Days	If less than one day
65 66	5		hrs. min.

9. Birthplace Gaithersburg, Md.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Basil Frazier
13. Birthplace Unknown

MOTHER
14. Maiden name Minnie Wilson
15. Birthplace Unknown

16. Informant Geo. W. Plummer
Address Gaithersburg, Md. R.7 D3

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 3. 1945 (mooth) (day) (yenr)
Cemetery or crematory Brooke Grove
Location Laytonsville, Md.
18. Funeral director Robt. L. Snowden
Address 246. N. Wash. St. Rockville
19. Feb 3 1945 (Date rec'd by registrar) Aluda G. Crapp Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January - 31 - 1945 at 9 45' P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 10 - 1944 to January 31 1945
and that I last saw her alive on January 30 - 1945

Immediate cause of death	DURATION
cerebral hemorrhage	25 days
Due to high arterial tension	years (3)
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE William C Mattes, M.D. M. D. or other
Address Gaithersburg, Md Date signed 2/3/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

00683

CERTIFICATE OF DEATH

Reg. Dist. No. 716

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda Md. Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24 hours
Hospital, Institution, or street address where death occurred: Suburban Hospital Assn. Inc.
How long in hospital or institution? 24 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: ... County: ...
City or town: Washington, D.C.
(If ontside city or town limits, write RURAL and give nearest town)
Street No. 4410 Albemarle St.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Mrs. Virgie Poore

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Joseph H. Poore
6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): October 22, 1875

8. AGE:

Years	Months	Days	If less than one day
69	3	4	... hrs. ... min.

9. Birthplace: Virginia, U.S.A. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: James Robey
13. Birthplace: Virginia, U.S.A.

MOTHER
14. Maiden name: Margaret Kidwell
15. Birthplace: Virginia, U.S.A.

16. Informant: Hospital Records (P. Goodall)
Address: 9600 Old Georgetown Rd, Bethesda

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/30/45 (month) (day) (year)
Cemetery or crematory: Cedar Hill Cem.
Location: Md.

18. Funeral director: Wm Reuben Trempley
Address: 7557 Wis. Ave. Bethesda

19. Jan 28 1945 (Date rec'd by registrar) Wm E Jobes MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 27 1945 at 1:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1944 to Jan 27 1945 and that I last saw h.e.r. alive on Jan 27 1945

Immediate cause of death	DURATION
Coronary thrombosis	2 days
Pulmonary edema	2 days
Due to: Arterial hypertension	3 years
Diabetes Mellitus	3 years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: Adam Kosa M.D.
M. D. or other
Address: 600 Nwada Ave NW Date signed Jan 27 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

00684

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH:
County Montgomery
City or town Rural Goshen Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Rural Goshen Md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Lucy Lane Prather

3. (b) Social Security Number —

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	Col	Single

6 (b) Name of husband or wife —
6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1879 Nov 24

8. AGE:

Years	Months	Days	If less than one day
65	1	10	hrs. min.

9. Birthplace Montgomery Co Md (Town, county, and state)
10. Usual occupation Nun
11. Industry or business —
FATHER 12. Name John W Prather
13. Birthplace Montgomery Co Md
MOTHER 14. Maiden name Lane
15. Birthplace Montgomery Co Md
16. Informant Mable C Fraga
Address Gaithersburg Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof January 8 1945 (month) (day) (year)
Cemetery or crematory Brooke Grove Md
Location Laytonsville Montg Co Md
18. Funeral director Roy W Barber
Address Laytonsville Md
19. 1/8/45 (Date rec'd by registrar) 19 C O Riell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 6 19 45, at 1:30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 14 19 44, to January 5 19 45, and that I last saw h- alive on January 5 19 45.

Immediate cause of death	DURATION
Myocardial degeneration	
Due to	
senile.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations —
Of autopsy —

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE Montgomery Co Md M. D. or other
Address Gaithersburg Md Date signed Jan 6, 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

00685

CERTIFICATE OF DEATH

Reg. Diat. No. 214

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County Montgomery

City or town Warner Ave Ken. Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution or street address where death occurred:
Miss Sinclair Nursing Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Montg

City or town 919 Sligo Ave.
(If outside city or town limits, write RURAL and give nearest town)

Street No. Silver Spring, Md.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Miss Hester A. Pyles.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Single.

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 14, 1857

8. AGE: Years 87 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Retired Practical Nurse

11. Industry or business

FATHER 12. Name William H. Pyles.

13. Birthplace Maryland.

MOTHER 14. Maiden name Annie E. Dolzell

15. Birthplace Maryland

16. Informant Mrs. Wickiam D. Coffey

Address 919 Sligo Ave. Silver Sp. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/8/45 (month) (day) (year)

Cemetery or crematory Rock Creek Cem.

Location Wash. D.C.

18. Funeral director Wm Reuben Humphrey

Address 7557 Wis. Ave. Bethesda, Md.

19. Jan. 7 19 45 (Date rec'd by registrar) Josephine M. Schaffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 6 19 45 at 6 A. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec. 30 1944 to Jan 6 1945 and that I last saw h[er] alive on Jan 5 1945

Immediate cause of death	DURATION
Cerebral hemorrhage	5 days
Due to (Pneumonia, Cerebral hemorrhage on Nov. 7, 1944)	
Due to	
Other conditions Generalized arterio-sclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Marion Bandstead M.D. M. D. or other

Address Silver Spring, Md. Date signed 1/6/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (178-B)

00686

CERTIFICATE OF DEATH

Reg. Dist. No. 212

1. PLACE OF DEATH:

County: Montgomery

City or town: Poolesville - outside
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Monty.

City or town: Poolesville Md
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Dewy Alton Reed

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Virginia Reed

6.(c) If alive, give age: 27 years

7. Birth date of deceased (mo., day, yr.): 1913

8. AGE: Years: 32 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Sophia, West Virginia (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER — 12. Name: Russell C. Reed

13. Birthplace: West Virginia

MOTHER — 14. Maiden name: Leona Fill

15. Birthplace: West Virginia

16. Informant: Cecil Reed

Address: Poolesville, Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof 1/20/45 (month) (day) (year)

Cemetery or crematory: Monocacy

Location: Beallsville, Md

18. Funeral director: William B. Hilliard

Address: Barnesville Md

19. Jan. 19, 1945. (Date rec'd by registrar) Charles A. Pyles Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 18, 1945 at 4:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 2nd Exam care, 19..., to ..., 19...

and that I last saw h... alive on ..., 19...

	DURATION
Immediate cause of death: Asphyxia	
Due to: Carbon monoxide poisoning (accidental)	Found dead
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accidental Date of 1-18-45

Where did injury occur? Poolesville (City or town) Monty (County) Md (State)

Injured at home, farm, industry, public place (where?) Found dead in car

Means of injury: Injured at work?

23. SIGNATURE: Frank J. Bronhard M.D.
Dep. Med. Exam. M. D. or other

Address: Hagerstown Md Date signed 1-18-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of year of birth is shown on FILM No. G 9 4 MAY 14 1945

00687

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50) K

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:
County: Montgomery
City or town: Capitol View
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Metropolitan Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 812 Sligo Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME: Minnie M Ross.

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Lewis Ross
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 20- 1878

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
66	3	13		

9. Birthplace: Kentucky (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: School Teacher.

FATHER
12. Name: Thomas J Johnson.
13. Birthplace: Kentucky

MOTHER
14. Maiden name: Ellen Hamblen
15. Birthplace: Kentucky

16. Informant: Mr Robert V Johnson - Brother
Address: 812 Sligo Ave. S.S.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 10 1945 (month) (day) (year)
Cemetery or crematory: George Washington Memorial
Location: Riggs Road Extended
18. Funeral director: Warner & Pumphrey
Address: 8433 Ga Ave - Silver Spring Md.

19. Jan 5 1945 (Date rec'd by registrar) Josephine M Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 3 1945, at 9:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1944, to Jan 3 1945
and that I last saw h[illegible] alive on Jan 3, 1945

Immediate cause of death	DURATION
Cerebral hemorrhage	1 day
Due to: Hypertensive heart disease	
Due to:	
Other conditions: Carcinoma of left breast	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J Marion Barnhard MD
M. D. or other
Address: Silver Spring, md Date signed: 1/3/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Sec 5 - Block C. Lot 1141 - Site 3.
George Washington Mem. Park.

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(1)

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (126)

00688

CERTIFICATE OF DEATH

Reg. Dist. No. 2223

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington San. & Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 709 Kennebec Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mrs. Ida M. Rowe

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Wh.	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1881

8. AGE: Years	Months	Days	If less than one day
63	0	22	hrs. min.

9. Birthplace Bay City, Michigan (Town, county, and state)

10. Usual occupation Retired Teacher

11. Industry or business

FATHER 12. Name THOMAS SIMONDS

13. Birthplace ONT. CANADA.

MOTHER 14. Maiden name LYDIA SHELTON

15. Birthplace ONT. CANADA.

18. Informant Washington Sanitarium Records

Address Takoma Park, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 18, 45 (month) (day) (year)

Cemetery or crematory Gegge Washington Mem. Cemetery

Location Prince Georges County, Md.

18. Funeral director J. Arthur Walters

Address 254 Carroll St. Washington D.C.

19. Jan 17 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 17 1945, at 6:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 14 1945, to Jan 17 1945

and that I last saw h[er] alive on Jan 16, 1945

Immediate cause of death	DURATION
Pulmonary atelectasis and Pulm. Edema & Infarcts	one day
Following: Cholecystectomy and Appendectomy	1-16-45
Due to: Chr. Diabetes and Chr. Cholecystitis	several years
Other conditions: Marked gen. Obesity old Chronic disease of Pancreas (Include pregnancy within 3 months of death)	years

Major findings of operation Gall stones Cholecystectomy and Appendectomy Date of op. 1-15-45

Autopsy results as noted above 1-17-45

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dead U. Calver M.D.

M. D. or other

7894 Galve Silver Spring, Md. Date signed 1-17-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

00689

Reg. Dist. No. 214

1. PLACE OF DEATH:
County: MONTGOMERY
City or town: NEAR KENSINGTON. (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: ST PAUL ST. KENSINGTON-HEIGHTS.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: MARYLAND County: MONTGOMERY
City or town: KENSINGTON HEIGHTS (If outside city or town limits, write RURAL and give nearest town)
Street No. ST PAUL ST (If rural, give LOCATION)
2.(a) If veteran, name war: NONE

3.(a) FULL NAME: Edward James Sabin

3.(b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife: BERTHA BELL
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): MARCH 24TH, 1869

8. AGE: Years	Months	Days	If less than one day
75	10	2	..... hrs. ..... min.

9. Birthplace: ST LOUIS - MO (Town, county, and state)
10. Usual occupation: RETIRED
11. Industry or business: U S GOVERMENT
FATHER 12. Name: LUTHER M. SABIN
13. Birthplace: ILL.
MOTHER 14. Maiden name: LILLIAN UNKNOWN.
15. Birthplace: ILL.
16. Informant: MRS BERTHA B SABIN
Address: ST PAUL ST. KENSINGTON. MD
17. Burial (Burial, cremation, or removal. Which?) Date thereof: JAN. 29. 45 (month) (day) (year)
Cemetery or crematory: ST MARY'S
Location: ROCKVILLE. MD
18. Funeral director: Warner & Pumphrey.
Address: 8036 GA AVE. SILVER SPRING. MD
19. Jan. 28 1945 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 26 1945; at 7:00 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1944 to Jan 26 1945
and that I last saw h... alive on ..... 19..

Immediate cause of death	DURATION
Coronary occlusion	died suddenly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Frank J. Brockett M.D. M. D. or other
Address: 20. Med. Arts Bldg Gaithersburg, Md Date signed 1-26-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

00690

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8302)

CERTIFICATE OF DEATH

Reg. Dist. No. 23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Washington Sanitarium & Hospital
How long in hospital or institution? 3 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 9 Mile Sligo (If rural give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mrs. Virginia P. Siegfried

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Mr. Frank Siegfried
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): April 27, 1889

8. AGE: Years	Months	Days	If less than one day
55	8	12	____ hrs. ____ min.

9. Birthplace: Washington, D.C. (Town, county, and state)
10. Usual occupation: Secretary
11. Industry or business: House of the Bldg.
FATHER 12. Name: Charles Morris
FATHER 13. Birthplace: Washington, D.C.
MOTHER 14. Maiden name: Katherine Nelson
MOTHER 15. Birthplace: Va.
16. Informant: Records Wash. San. & Hosp.
Address: Takoma Park, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 11, 1945 (month) (day) (year)
Cemetery or crematory: Fort Lincoln Cemetery
Location: Bladensburg Rd. Md
18. Funeral director: Warner C. Pumphrey
Address: Silver Spring Md.
19. 1-9 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 8 1945, at 4 05 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jany 7 1945 to Jan. 8 1945
and that I last saw h[illegible] alive on Jan 8 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	5 hours.
Due to	
Due to Hypertension ?	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ____ Injured at work?

23. SIGNATURE: John N. Andrews M.D. M. D. or other
Address: Silver Spring Md. Date signed 1-8-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

00691

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Suburban Hospital
How long in hospital or institution? 43 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5513 Glenwood Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Christine Sloan

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	

6.(b) Name of husband or wife George G. Sloan
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) Sept. 14, 1864

8. AGE: Years	Months	Days	If less than one day
80	4	1	..... hrs. ..... min.

9. Birthplace Norway (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden name Unknown
15. Birthplace

16. Informant
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 17, 1945 (month) (day) (year)
Cemetery or crematory Glenwood Cemetery
Location Washington D.C.
16. Funeral director L.P. Jones Co
Address 2901-14 St NW

19. Jan 15 1945 (Date rec'd by registrar) Wm Elder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 14- 1945, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 31 1944, to Jan 15 1945
and that I last saw h[illegible] alive on Jan 14 1945

Immediate cause of death	DURATION
Cardiac decompensation	3 days
Due to Cardiovascular Renal disease	
Due to	
Other conditions Pyelonephritis Postmenopausal Chronic	

(Include pregnancy within 3 months of death)
Major findings of operations Sepsis
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Elizabeth Clubbering
M. D. or other
Address 360 Town Ave Date signed 1-15-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (44C)

CERTIFICATE OF DEATH

00692

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If ontside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 mo., 20 da
Hospital, institution, or street address where death occurred:
USNH, Bethesda, Md.
How long in hospital or institution? 3 mo.,20 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Bethesda, Md.
(If ontside city or town limits, write RURAL and give nearest town)
Street No. 5509 Glen Fair Glen Rd
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Hale Bryan SOYSTER, Lt. Comdr. USNR

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W-US	married

6.(b) Name of husband or wife: Elizabeth Soyster
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 11-1-99

8. AGE: Years	Months	Days	If less than one day
45	2	23	hrs. min.

9. Birthplace: Minnesota
(Town, county, and state)
10. Usual occupation: Navy
11. Industry or business:

FATHER
12. Name: Lloyd Soyster
13. Birthplace: Iowa

MOTHER
14. Maiden name: Luella Hammone
15. Birthplace: Illinois

16. Informant: Wife: Mrs. Elizabeth Soyster
Address: 5509 Fair Glen Rd, Bethesda, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-26-45 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Virginia

18. Funeral director: W. W. Chambers (W. W. C.)
Address: 1400 Chapin St. N.W., Wash, D.C.

19. Jan. 24 19 45 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 24 January 19 45, at 2.54 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4 October 19 44, to 24 January 19 45
and that I last saw him alive on 23 January 19 45

Immediate cause of death	DURATION
Sarcoidosis (uveo-parotid fever)	6 mo.
Due to	
Due to	
Other conditions	

(Incinde pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Howard M. Odell Lt. MC-USNR or other
Address: U.S. Naval Hospital Date signed: 1-24-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

00693

Reg. Dist. No. 7-23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: MONTGOMERY

City or town: TAKOMA PARK

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 MONTHS.

Hospital, institution, or street address where death occurred:

209 HOLLY AVE.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: MONTG.

City or town: TAKOMA PARK

(If outside city or town limits, write RURAL and give nearest town)

Street No. 209 HOLLY AVE.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: GEORGIANA STEBBINS.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): AUG. 20, 1864.

8. AGE: Years: 80 | Months: 4 | Days: 15 | If less than one day: ..... hrs. ..... min.

9. Birthplace: OTTOWA, ILLINOIS. (Town, county, and state)

10. Usual occupation: TEACHER

11. Industry or business: PUBLIC SCHOOLS.

FATHER

12. Name: GEO. STEBBINS

13. Birthplace: MASS.

MOTHER

14. Maiden name: ANNA C. WESTON

15. Birthplace: MAINE.

16. Informant: MARAH STEBBINS.

Address: 209 HOLLY AVE.

17. CREMATION (Burial, cremation, or removal. Which?) Date thereof JAN. 5 1945 (mooth) (day) (year)

Cemetery or crematory: Cedar Hill Cemetery

Location: Penna Ave. Extended - Co. Georgetown Md

18. Funeral director: Arthur J. Walker

Address: 254 Carroll Ave. Takoma Park D.C.

19. Jan 6 1945 (Date rec'd by registrar) J. Milton Redd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JANUARY 4 1945 at 9.15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 5 1944 to Jan. 4, 1945 and that I last saw h.. alive on Jan. 4 1945

Immediate cause of death	DURATION
Arteriosclerosis	Indefinite
Due to: Senility	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: C. B. Kelly M.D. M. D. or other

Address: 6911 5th st. NW. Washington D.C. Date signed Jan. 7/45

00694

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs - 1 day

Hospital, institution, or street address where death occurred:
Washington Sanitarium and Hospital

How long in hospital or institution? 5 yrs - 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State ..... County .....

City or town Washington D.C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 815 Ingeham N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME

Mrs Nettie Sullivan

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Femaie	White	Widowed

6.(b) Name of husband or wife Mr. William Sullivan

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 29 1878

8. AGE: Years	Months	Days	If less than one day
66	8	15	..... hrs. ..... min.

9. Birthplace Alexandria, Virginia
(Town, county, and state)

10. Usual occupation House Wife

11. Industry or business

FATHER
12. Name Charles F. Potter
13. Birthplace Virginia

MOTHER
14. Maiden name Elizabeth Trice
15. Birthplace Virginia

16. Informant Hospital Records
Address

17. Burial, cremation, or removal. Which?) Removal Date thereof Jan 13 1945 (month) (day) (year)

Cemetery or crematory .....

Location Washington D.C.

18. Funeral director L.H. Hines Co

Address 2901 - 14th N.W.

19. (Date rec'd by registrar) Jan 13 1945 ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 13 1945 at 3.59 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 44, to Jan. 13 19 45

and that I last saw her alive on Jan. 13 19 45

Immediate cause of death	DURATION
Acute congestive Heart failure	7 days
Due to Acute Septicemia & Hemolytic strep - acute	4 days 6 days
Due to Rheumatoid Arthritis	5 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations 0

Date of op. 0

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE John A. Brownsberger - M.D.
M. D. or other

Address Takoma Park - D.C. Date signed 1/13/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for change of year of birth of deceased is shown on FILM No. G 9 4 MAY 14 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 89

00695

CERTIFICATE OF DEATH

Reg. Dist. No. 213-

1. PLACE OF DEATH:
County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 109- East Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Olney
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Clara L Thompson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	White	Single

6.(b) Name of husband or wife: None

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 30 - 1866 1867

8. AGE: Years 77 | Months 5 | Days 3 | If less than one day ..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Snowden Thompson
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Hull
15. Birthplace: Maryland

16. Informant: Mrs. Bro Clagett
Address: Glen - Rt 1 - Rockville - Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 4 - 1945 (month) (day) (year)
Cemetery or crematory: Catholic Church Cem -
Location: Clarksville - Howard Co Md

18. Funeral director: Wm. Reuben Humphrey
Address: Rockville - Maryland

19. 1/3 (Date rec'd by registrar) 1945 Josephine D. Hoffman Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 2 19 45 at 4P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 11 19 44 to January 2 19 45
and that I last saw h.. alive on Jan. 2nd 19 45

Immediate cause of death	DURATION
Cerebral apoplexy	sudden
Due to: arteria sclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: G. O. Hartley M.D. M. D. or other
Address: Rockville Md Date signed 1/3/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (41-a)

CERTIFICATE OF DEATH

00696 2 1 2
Reg. Dist. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Montgomery
City or town: R F D Poolesville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 da
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: R.F.D. Poolesville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Sugarland (Rural)
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Wm. Henry Weedon.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Negro	—

6.(b) Name of husband or wife: —
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Jan 15th 1945

8. AGE: Years | Months | Days: 4 | If less than one day: — hrs. — min.

9. Birthplace: Sugarland R 7 D # 1 Poolesville Md
(Town, county, and state)
10. Usual occupation: —
11. Industry or business: —
FATHER 12. Name: George Weedon (Buckeyetown Md)
FATHER 13. Birthplace: R 7 D Poolesville Md (Sugarland)
MOTHER 14. Maiden name: Alberta Beander
MOTHER 15. Birthplace: Sugarland R 7 D Poolesville Md
16. Informant: Alberta Weedon (Mother)
Address: R 7 D # 1 - Poolesville Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-15-45 (month) (day) (year)
Cemetery or crematory: Sugarland Cold Church.
Location: Sugarland, Md.
16. Funeral director: Parent. Geo F. Weedon.
Address: R 7 D # 1 Poolesville Md
19. 1/15/45 (Date rec'd by registrar) 19... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. Dec 15th 19 45 at 11 A M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 11. 1945 to Jan 15. 1945 and that I last saw him alive on Jan 15. 1945

Immediate cause of death	DURATION
Pulmonary Atelectasis	4 hrs
Due to: not determinable.	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Upton D Thomas M.D
M. D. or other
Address: Dawsonville Md Date signed Dec 15/44 Jan. 1/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

00697

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:
County Montgomery
City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? —
Hospital, institution, or street address where death occurred:
15 Woodmoor Drive
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 15 Woodmoor Drive
(If rural, give LOCATION)
2.(a) If veteran, name war Wored #1

3.(a) FULL NAME Forrest G. Wilcox

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Helen H. Wardell
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 20, 1878

8. AGE: Years	Months	Days	If less than one day
66	2	11	..... hrs. ..... min.

9. Birthplace Rhode Island (Town, county, and state)
10. Usual occupation Retired
11. Industry or business Builder

FATHER
12. Name George Wilcox
13. Birthplace Rhode Island

MOTHER
14. Maiden name Unknown Caroline P. Clements
15. Birthplace Rhode Island

16. Informant Mrs. Helen H. W. Wilcox
Address 15 Woodmoor Drive, Silver Spring, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 4, 1945 (month) (day) (year)
Cemetery or crematory Rock Creek Cemetery
Location Washington, D. C.

16. Funeral director Warner E. Pumphrey
Address Silver Spring, Md.

19. Jan. 3 (Date rec'd by registrar) 19 45 Josephine M. Schaffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 1, 1945 at 7 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 29 1944 to Jan. 1 1945 and that I last saw h.. alive on Jan. 1, 1945

Immediate cause of death	DURATION
Congestive Heart Failure	4 days
Due to Chronic Myocarditis	duration
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE C. B. Fahey, M.D. M. D. or other
Address 6911 Sligo St. N.W. Washington, D.C. Date signed Jan. 1, 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

00698

Reg. Diat. No. 218

1. PLACE OF DEATH:
County Montgomery
City or town Rural Germantown md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Under 1 year
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary Sohkronia Wims

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col	married

6.(b) Name of husband or wife William N. Wims
6.(c) If alive, give age 65 years
7. Birth date of deceased (mo., day, yr.) Nov 10 - 1883

8. AGE: Years	Months	Days	If less than one day
61	2	11	hrs. min.

6. Birthplace Montgomery Co Md (Town, county, and state)
10. Usual occupation House Wife
11. Industry or business Home
FATHER 12. Name James Mason
13. Birthplace Montgomery Co Md
MOTHER 14. Maiden name Lavinia Frazier
15. Birthplace Montgomery Co Md
16. Informant Eva Wims Stewart
Address Washington D.C.
17. Burial (Burial, cremation, or removal. Which?) Date thereof January 24 1945 (month) (day) (year)
Cemetery or crematory Rockville
Location near Clarksburg Md
16. Funeral director Roy W. Barber
Address Laytonsville Md
19. Jan. 23 1945 Edward L Cooke
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 21 1945 at 12 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 1942, to Jan 21 1945
and that I last saw h.er alive on Jan 20 1945

	DURATION
Immediate cause of death acute heart failure	1/4 hr.
Due to Myocardial degeneration	2½ yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. C. Miller, M.D.
M. D. or other
Address Gaithersburg Md Date signed 1-23-45

00699

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-a)

CERTIFICATE OF DEATH

Reg. Diat. No. 618

1. PLACE OF DEATH:
County Montgomery
City or town Gaithersburg R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Gaithersburg R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mary L Young

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	Widowed

6.(b) Name of husband or wife John Franklin Young
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 10 1867

8. AGE: Years 77 | Months 9 | Days 19 | If less than one day ... hrs. ... min.

9. Birthplace Montgomery Co Md
(Town, county, and state)

10. Usual occupation Domestic

11. Industry or business None

FATHER
12. Name Robert Warfield
13. Birthplace Howard Co Md

MOTHER
14. Maiden name Rachel Hobbs
15. Birthplace Howard Co Md

16. Informant Mrs Gladys Young
Address Baltimore Md 2 Lamar

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 31 '45 (month) (day) (year)
Cemetery or crematory Damascus Md
Location Montgomery Co Md

18. Funeral director Paul W Barber
Address Gaithersburg Md

19. 1/31 1945 (Date rec'd by registrar) E O Buck Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 29 1945, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 28 1945 to Jan 29 1945
and that I last saw him alive on Jan 28 1945

Immediate cause of death	DURATION
Acute Myo-Cardiatis	2 days
Due to Unknown Cause	
Due to	
Other conditions Nil	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Vernon H Dyson M D
M. D. or other
Address Gaithersburg Md Date signed Jan 30/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

1117111

Reg. Diat. No. 218

1. PLACE OF DEATH:

County Montgomery

City or town Olney, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
The Montgomery County General Hospital Inc.

How long in hospital or institution? 1 day.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Washington Grove
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME William Henry Zacharias

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male.	White	Single.

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 21. 1945

8. AGE: Years | Months | Days | If less than one day: 6 hrs. 50 min.

9. Birthplace Olney, Montgomery County, Maryland
(Town, county, and state)

10. Usual occupation Infant

11. Industry or business

FATHER 12. Name Paul Theodore Zacharias

FATHER 13. Birthplace Brooklyn, New York.

MOTHER 14. Maiden name Louella Mathilda Bohner

MOTHER 15. Birthplace Knoxville, Tennessee

16. Informant Hospital records.

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/23/45 (month) (day), (year)

Cemetery or crematory Oak Rose Cemetery

Location Olney Md.

18. Funeral director E. E. Gaither

Address Gaithersburg Md.

19. Jan. 23 1945 Ruth G. Cook
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 23 1945, at 12:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 21 1945, to January 23 1945 and that I last saw h.. alive on January 23 1945

Immediate cause of death	DURATION
(a) Prematurity	—
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M.D.
M. D. or other

Address Sandy Spring, Md. Date signed 1-23-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15